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BENEFITS BRIEF

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Department of Labor Proposes Complex Procedures for Disability Benefit Claims; Changes Would Increase Litigation Risk

On November 18, 2015, the Department of Labor (the "Department") published proposed amendments to the claims procedure regulations for ERISA plans providing disability benefits ("Proposed Rule"). 80 Fed. Reg. 72014. The Department states that its intent is to extend the procedural rules that apply to health care claims under the Affordable Care Act ("ACA") (which were also finalized on November 18, 2015) to disability claims. The disability changes would take effect 60 days after publication of the final rule. Written comments are due by January 19, 2016.

Major Concerns

The Proposed Rule would almost certainly increase the administrative costs and burdens of administering disability plans, and would encourage claimants to pursue their claims in court. Disability plans should consider what changes may be required if the final rule goes into effect as quickly as proposed, and how to minimize costs and litigation risk. Changes of concern include:

- Disclosure of the Basis for Disagreeing with a Third Party: Adverse benefit determinations would have to contain a discussion of the decision, including the basis for disagreeing with any disability determination by the Social Security Administration, a treating physician, or other third party disability payor presented by the claimant, to the extent the plan did not follow those determinations. It is unclear how a plan can protect itself when its doctors disagree with the treating physician, for example.

- Strict Compliance and Possible De Novo Review: If the plan fails to strictly adhere to all the claims requirements, the reviewing court would not give special deference to the plan's decision, but would review the dispute de novo. The proposal allows for a minor errors exception, which would apply only when a violation was (1) *de minimis*, (2) non-prejudicial, (3) attributable to good cause or matters beyond the plan's control, (4) in the context of an on-going good faith exchange of information, **and** (5) not reflective of a pattern or practice of noncompliance. The strict compliance standard will encourage claimants to litigate, in the hope that a judge will ignore the plan's decision and review de novo. The Department's stated rationale, in part, for the Proposed Rule is "the volume and constancy of litigation in this area;" it would appear that the Department seeks to give claimants an edge in court that they do not currently enjoy.

- Right to Review and Respond to New Information Before Final Decision: Prior to a decision on appeal, the plan would be required to provide to the claimant, free of charge, any new or additional evidence considered, relied upon, or generated by (or at the direction of) the plan in connection with the claim, as well as any new or additional rationale for a denial. The claimant must then be given a reasonable opportunity to respond to such new or additional evidence or rationale. The Proposed Rule does not state how a plan can meet existing deadlines for a decision while adding this extra step to the appeals process.

I. Background

ERISA Claims Requirements. Section 503 of ERISA requires every employee benefit plan, in accordance with regulations of the Department, to "provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant" and to "afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim."

The Department has previously published (and revised) regulations to establish minimum requirements for benefit claims procedures for employee benefit plans covered by ERISA, including disability plans (the "DOL Claims Rule"). *See, e.g.*, 42 Fed. Reg. 27426 (May 27, 1977); 65 Fed. Reg. 70246 (Nov. 21, 2000), amended at 66 Fed. Reg. 35887 (July 9, 2001).

ACA Claims Requirements. The ACA added Section 2719 of the Public Health Service Act ("PHSA"), which provides that certain **group health plans** must have in effect an internal claims and appeals process and that such plans must initially incorporate the claims and appeals processes set forth in the DOL Claims Rule and update such processes in accordance with standards established by the Department. The ACA did not amend ERISA's disability claims requirements.

On July 23, 2010, the Departments of Health and Human Services, Labor, and the Treasury (the "Departments") issued interim final regulations implementing the new ACA claims requirements (the "ACA Claims Rule"). 75 Fed. Reg. 37188 (June 28, 2010); 75 Fed. Reg. 43330 (July 23, 2010); 76 Fed. Reg. 37208 (June 24, 2011). On November 18, 2015, the Departments published the final ACA Claims Rule. 80 Fed. Reg. 72192. The final rule adopts and clarifies the new requirements in the ACA Claims Rule that apply to internal claims and appeals processes for non-grandfathered group health plans.

II. Proposed Rule

The Proposed Rule imports to disability plans the updated standards of the ACA for non-grandfathered group health plans. As the Department notes, the proposed changes also apply to retirement or welfare plans that provide disability benefits. Accordingly, the proposed changes would apply to defined benefit plans that provide continued accruals for participants on long-term disability (including stopping accruals when a participant recovers), and to 401(k) or 403(b) plans, for example, that allow distributions on account of a participant's "disability."
Below is a summary of some of the key issues raised by the proposed amendments to the claims procedure regulations for disability plans.

Conflicts of Interest

The DOL Claims Rule already contains certain standards of independence for persons making claims decisions. The Proposed Rule would add to these standards by providing new criteria for avoiding conflicts of interest. Specifically:

- Plans providing disability benefits would have to "ensure that all disability benefit claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision."

- Decisions regarding hiring, compensation, termination, promotion, or similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based on the likelihood that the individual will support the denial of disability benefits.

Greatly Expanded Disclosure Requirements

The Proposed Rule would require disability plans to provide three additional pieces of information in connection with an adverse benefit determination:

- A discussion of the decision, including the basis for disagreeing with any disability determination by the Social Security Administration ("SSA"), a treating physician, or other third party disability payor presented by the claimant, to the extent that the plan did not follow those determinations.

- The internal rules, guidelines, protocols, standards or other similar criteria that the plan relied upon in denying the claim (or a statement that these do not exist).

- A statement that the claimant is entitled to receive, upon request, documents relevant to the claim for benefits.

The requirement to include the basis for disagreeing with any third party disability determination could prove particularly burdensome. It may be difficult to obtain, on a timely basis, the information that supports a third party disability determination, such as from the SSA. In addition, it is unclear what type of explanation would be an adequate basis for disagreeing with a third party disability determination. Further clarification around this new requirement would be welcome.

Right to Review and Respond to New Information Before Final Decision

The Proposed Rule would also add additional requirements, purportedly to ensure a full and fair review of denied disability claims. Specifically, the Proposed Rule would require a disability plan to:

- Allow a claimant to review the claim file and to present evidence and written testimony as part of the disability benefit claims and appeals process.

- Provide free of charge, prior to a plan's decision on appeal, any new or additional evidence considered, relied upon, or generated by (or at the direction of) the plan in connection with the claim. This information must be provided as soon as possible and in advance of the plan's decision on appeal to give the claimant a reasonable opportunity to respond to such new or additional evidence.

- Provide free of charge, prior to a plan's decision on appeal, any new or additional rationale that will form the basis for the plan's decision on appeal. This information must be provided as soon as possible, and in advance of the plan's decision on appeal, to give the claimant a reasonable opportunity for the claimant to respond to such new or additional rationale.

In the Preamble, the Department provides an example of how these new provisions would work. In the example, the plan denies a claim at the initial stage based on a medical report generated by the plan administrator. The claimant appeals the denial, and during its 45-day decision period, the plan administrator causes a new medical report to be generated by a medical specialist who was not involved with developing the first medical report. According to the Department, the Proposed Rule would require the plan to take the following steps:

- Automatically furnish to the claimant any new evidence in the second report, furnishing this evidence as soon as possible and sufficiently in advance of the 45-day deadline;
- Consider any response from the claimant;
- If the claimant's response caused the plan to generate a third medical report containing new evidence, the plan would have to automatically furnish to the claimant any new evidence in the third report; and
- The new evidence from the third report would have to be furnished as soon as possible and sufficiently in advance of the 45-day deadline.

These new requirements would add cost and likely complicate compliance with the existing timing rules. Comments are requested on whether, and to what extent, modifications to the existing timing rules are needed to ensure that disability benefit claimants and plans will have ample time to engage in the back-and-forth dialogue contemplated by the new review and response rights.

Deemed Exhaustion of Claims and Appeal Processes / Strict Adherence

The Proposed Rule would revise the deemed exhaustion provision of the DOL Claims Rule in three ways:

- If the plan failed to strictly adhere to the rules for processing disability claims, a claimant would be deemed to have exhausted the administrative procedures under the plan and shall be entitled to sue under a de novo standard, unless the minor errors exception applied. The claimant would be entitled, upon request, to an explanation of the plan's basis for asserting that it meets this standard. The Plan would have 10 days to respond to the claimant's request.
- In those situations when the minor errors exception did not apply, the reviewing court would not give special deference to the plan's decision, but rather would review the dispute de novo.
- If a court rejected the claimant's request for immediate review on the basis that the plan met the standards for the minor errors exception, the claim would be considered as re-filed on appeal upon the plan's receipt of the decision of the court. In addition, within a reasonable time after the receipt of the decision, the plan would be required to provide the claimant with notice of the resubmission.

Coverage Rescissions – Adverse Benefit Determinations

The Proposed Rule would address coverage rescissions not already covered under the DOL Claims Rule. The DOL Claims Rule already covers a rescission if the rescission is the basis, in whole or in part, of an adverse benefit determination. Other rescissions, however, may not be covered by the DOL Claims Rule (e.g., rescissions as the result of audits). The Proposed Rule would amend the definition of an adverse benefit determination to include, for plans providing disability benefits, a rescission of disability benefit coverage that has a retroactive effect, whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time.

Culturally and Linguistically Appropriate Notices

The Proposed Rule would require that adverse benefit determinations be provided in a "culturally and linguistically appropriate manner" in certain situations. For example, if a claimant's address is in a county where 10 percent or more of the population of that county are literate only in the same non-English language, notices of adverse benefit determinations to the claimant would have to include a prominent one-sentence statement about the availability of language services. In addition, the plan would be required to provide oral customer assistance in the non-English language applicable to that county, and provide written notices in the non-English language upon request. Such non-English languages include Spanish, Chinese, Tagalog, and Navajo.

Statute of Limitations

Finally, the Department solicits comments on whether the final regulation should require plans to provide claimants with a clear and prominent statement of any applicable contractual limitations period and its expiration date for the claim at issue in the final notice of adverse benefit determination on appeal and with an updated notice of that expiration date if tolling or some other event causes that date to change.

Conclusion

The Proposed Rule would add complexity to processing disability claims, and for defending adverse decisions. Claim denials would have to include the basis for disagreeing with third party disability determinations; courts would review a plan's decision de novo in the case of procedural errors (unless the error was minor), and claimants would have the right to review and respond to new information before the plan makes a decision on appeal. As a result, plans providing disability benefits should carefully review the Proposed Rule to determine the potential impact of these changes.

Please contact any of the attorneys in the Health and Welfare Practice Group at Groom Law Group or your regular Groom Law Group attorney for further information.