GROOM LAW GROUP CHARTERED

BENEFITS BRIEF

January 25, 2018 www.groom.com

If you have questions, please contact your regular Groom attorney or one of the attorneys listed below:

Alvaro Anillo
aanillo@groom.com
(202) 861-6621

David Ashner
dashner@groom.com
(202) 861-6330

Michael Kreps
mkreps@groom.com
(202) 861-5415

David Levine
dlevine@groom.com
(202) 861-5436

Matthew Muma
mmuma@groom.com
(202) 861-5405

Seth Perretta
sperretta@groom.com
(202) 861-6335

Allison Ullman
aullman@groom.com
(202) 861-6336

New Disability Claims Procedure Rules To Take Effect In April 2018: Disability Plans and Many Retirement Plans Affected

The U.S. Department of Labor ("DOL") recently announced that final regulations updating the process requirements for claims involving disability benefit determinations (the "Final Rule," 81 Fed. Reg. 92316 (Dec. 19, 2016)) will take effect for claims after April 1, 2018. The Final Rule attempts to harmonize the rules governing disability claims with the requirements applicable to group health plans under the Patient Protection and Affordable Care Act ("ACA"). DOL previously delayed the applicability date of the Final Rule for 90 days to conduct a review of the potential effects but has now concluded that the agency will not further delay or change the claims regulations. Plan sponsors should carefully review their plans to determine what changes are necessary.

A. Steps To Take Before April 2018

The Final Rule applies to disability claims filed after April 1, 2018. Prior to April 2018, sponsors of disability plans and other plans (*e.g.*, defined benefit plans, 401(k)s, ERISA-covered 403(b)s, and top hat plans) making their own disability determinations should:

- Review claims provisions of plan documents to conform with the requirements of the Final Rule;
- Review and update descriptions of claims procedures in summary plan descriptions;
- Review service agreements with any outsourced disability vendors to determine who has responsibility for compliance and liability for any failures to comply with the requirements in the Final Rule; and
- Review existing and updated internal or external provider disability claims process flows, materials, template materials, and other communications to ensure compliance with the Final Rule.

B. Key Procedural Requirements Reflected In The Final Rule

The Final Rule is very likely to increase the administrative costs and burdens of administering disability benefits under ERISA plans and is likely to make it easier for claimants to pursue their claims in court. Key changes to the procedures that ERISA plans must use to process disability claims include:

- **Disclosure of the Basis for Disagreeing with a Third Party**. Adverse benefit determinations have to contain a discussion of the decision, including the basis for disagreeing with any disability determination by the Social Security Administration ("SSA") or the views of any treating physician or vocational professional who evaluated the claimant.

- **Right to Review and Respond to New Information Before Final Decision**. Prior to a decision on appeal, a plan will 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.

- **Strict Compliance and Possible De Novo Review**. If a plan fails to strictly adhere to all ERISA procedural requirements when processing a disability claim (except for certain minor errors), this failure may now trigger the claimant's right to file a lawsuit in court under section 502(a) of ERISA, even before the plan's procedures are exhausted. In that case, a court may not give special deference to the plan's decision but may review the dispute de novo. Discovery, including depositions, may be allowed to examine whether procedural violations affect the standard of review.

C. Detailed Discussion Of The Final Rule

The Final Rule broadly applies a number of the ACA claims procedure rules to ERISA plan disability claims. Below is a summary of the key issues raised by the Final Rule.

1. Conflicts of Interest

The Final Rule provides new criteria for avoiding conflicts of interest. Specifically –

- Plans providing disability benefits have to "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 decision," and;

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

2. Greatly Expanded Disclosure Requirements

The Final Rule requires plans to provide several additional pieces of information in connection with any adverse determination of a disability claim. Specifically, plans must provide the following:

- A discussion of the decision, including an explanation of the basis for disagreeing with or not following (a) any SSA disability determination presented by a claimant, and (b) the views of a treating physician or vocational professional who evaluated a claimant, regardless of whether the information was presented by the claimant or obtained on the plan's behalf. A plan must provide such information generated on the plan's behalf regardless of whether the plan relied on the advice in reaching its determination.

- 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 or a statement that such explanation will be provided free of charge upon request.

- The specific 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.

Although DOL revised the proposed rule to eliminate a requirement that plans discuss all third-party payor decisions presented by a claimant, the requirement to discuss the basis for disagreeing with SSA disability determinations could still prove burdensome. For example, it may be difficult to obtain relevant information from the SSA on a timely basis.

3. Right to Review and Respond to New Information Before Final Decision

The Final Rule requires plans to provide, free of charge and prior to a plan's adverse decision on appeal, any new or additional evidence or rationale for denial considered, relied upon, or generated by (or at the direction of) the plan, insurer, or other person making the benefit determination in connection with the appeal. This evidence or rationale must be provided as soon as possible and sufficiently in advance of the date that the plan's decision on appeal is due, in order to give the claimant a reasonable opportunity to respond to such new or additional evidence or rationale. In the preamble to the Final Rule, DOL provides an example of how these new provisions will work. In the example, a plan denies a claim at the initial stage based on a medical report generated by the plan administrator. The claimant appeals the denial, and the plan administrator then causes a new medical report to be generated. According to DOL, the Final Rule requires the plan to take the following steps:

- Automatically furnish to the claimant any new or additional evidence in the second report as soon as possible and sufficiently in advance of the deadline for a decision;

- Consider any response from the claimant;

- If the claimant's response causes the plan to generate a third medical report containing new or additional evidence, the plan must automatically furnish this new report to the claimant as soon as possible and sufficiently in advance of the deadline for a decision;

- Consider any response from the claimant.

If the new evidence or rationale for denial is not provided to the claimant as described above, the plan cannot rely on the evidence or rationale in denying the appeal. These new requirements could add costs and will likely complicate compliance with the existing timing rules.

4. Deemed Exhaustion of Claims and Strict Compliance

The Final Rule revises the deemed exhaustion provision of the current regulations in the following ways:

- If a plan fails to strictly adhere to all rules for processing disability claims, a claimant will be deemed to have exhausted the plan's administrative procedures and shall be entitled to file a lawsuit, unless the minor errors

exception applies. The minor errors exception applies only when a violation of the required claims procedures 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 claimant is entitled, upon request, to an explanation of the violation from the plan. The plan has ten days to respond to such a request.

- A claimant who is not satisfied with the plan's explanation, or a claimant who does not even request an explanation, may file suit for benefits. The claimant is likely to allege that the court should decide the case de novo, even if the plan has decided the claim and a deferential standard of review would otherwise apply. Discovery about the plan's practices and procedures may ensue, including depositions, to determine whether a minor errors exception should apply.

- If a court rejects a claimant's request for immediate review on the basis that the plan satisfied the minor errors exception, the claim will be considered as re-filed on appeal upon the plan's receipt of the court's decision. In addition, within a reasonable time after the receipt of the decision, the plan will be required to provide the claimant with notice of the resubmission.

5. Coverage Rescissions – Adverse Benefit Determinations

Current regulations already cover a rescission if the rescission is the basis, in whole or in part, of an adverse benefit determination. Other rescissions may not currently be covered by the regulations (*e.g.*, rescissions as the result of audits). The Final Rule amends the definition of an adverse benefit determination to include any rescission of disability benefit coverage that has a retroactive effect, except to the extent the rescission is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage. This rule applies whether or not there is an adverse effect on any particular benefit at that time.

6. Culturally and Linguistically Appropriate Notices

The Final Rule requires that adverse benefit determinations be provided in a "culturally and linguistically appropriate manner" if a claimant's address is in a county where ten percent or more of the population of that county are literate only in the same non-English language. For such claimants, notices of adverse benefit determinations must include a prominent one-sentence statement about the availability of language services, and upon request, the notice must be provided in the other language. In addition, plans are required to provide oral customer assistance in the non-English language applicable to that county. In 2016, such non-English languages included Spanish, Chinese, Tagalog, and Navajo.

7. Statute of Limitations

The Final Rule requires plans to provide claimants with a description of any applicable contractual limitations period and the expiration date relevant to the claim at issue.