Portfolio Media. Inc. | 111 West 19th Street, 5th Floor | New York, NY 10011 | www.law360.com
Phone: +1 646 783 7100 | Fax: +1 646 783 7161 | customerservice@law360.com

Inside The Final DOL Regulations On Disability Claims

By **Arthur Marrapese** (February 26, 2018, 2:10 PM EST)

Arthur Marrapese

The U.S. Department of Labor recently announced that April 1, 2018, will be the effective date of regulations detailing the new federal standards that apply to an Employee Retirement Income Security Act plan's administrative process for resolving disputes involving disability benefits. The new rule applies to disability claims filed after April 1, 2018. The new standards will likely require amendments to most ERISA-governed disability plans, and other ERISA-governed benefit arrangements that confer benefits based on a participant's (or beneficiary's) disability.

The new rules apply to any ERISA-covered plan under which the claims fiduciary has discretionary authority to determine whether a participant or beneficiary is disabled. When a plan provides a benefit the availability of which is conditioned on a finding of disability made by a party other than the plan, (e.g., the Social Security Administration or the employer's long-term disability plan), then a claim for benefits is not treated as a disability claim for purposes of the new rule.

Background

ERISA-governed employee benefit plans must maintain procedures for resolving benefit plan disputes. Longstanding DOL regulations detail the specific standards and requirements that govern the claims dispute process. The regulations are designed to ensure that any participant or beneficiary whose claim for benefits has been denied receives notice, in writing, of the reasons for the denial, and is afforded a reasonable opportunity for a full and fair review of the decision denying the claim.

Employers and claims fiduciaries (e.g., plan administrators, benefit committees, insurers and third-party service providers to whom claims responsibilities have been delegated) have powerful incentives to ensure that a plan's administrative procedure for deciding claims is conducted in compliance with the detailed requirements of the DOL's claims regulations. Courts routinely dismiss lawsuits by claimants who fail to exhaust their administrative remedies (e.g., the claimant attempts to end-run the plan's claims procedure or files suit before the claims fiduciary's final determination) where the claimant had a full and fair opportunity to challenge the benefits denial. Perhaps more importantly, if a claims fiduciary has the requisite discretionary authority to decide claims, a court will be inclined to uphold the fiduciary's decision unless the court finds that the fiduciary's decision was arbitrary and capricious, or did not substantially comply with the DOL's claims regulation. Where there is "substantial"

noncompliance, a reviewing court will apply a "de novo" standard of review.[1] Under the "de novo" standard, a court may substitute its own judgment for the judgment of the claims fiduciary, even where the fiduciary's judgment would be considered reasonable.

For the reasons discussed in more detail below, the new regulations will make it much more difficult for disability plans to bind claimants to the plan's claims procedure (i.e., to enforce the exhaustion requirement) and ensure that final claim denials that end up in court are reviewed under a deferential review standard.

Summary of Key Requirements

Conflicts of Interest

Claims and appeals must be adjudicated in a manner that is designed to ensure the independence and impartiality of the persons involved in making the benefit determination. [2] Accordingly, decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to any individual (such as a claims adjudicator or medical or vocational expert) must not be made based upon the likelihood that the individual will support the denial of benefits. For example, a plan's decision to retain a particular medical or vocational expert cannot be based on the expert's reputation for supporting benefit denials.

Opinions of Third Parties That Support a Finding of Disability

Claims fiduciaries cannot dismiss the recommendations of a claimant's health care or vocational expert, or a disability benefit determination of the Social Security Administration, without providing an explanation of the basis for disagreeing with or not following the expert's opinion or Social Security Administration's determination. The same requirement applies to the views of experts retained by the plan even if the claims fiduciary did not rely on the expert's advice in making the decision to deny a benefit.[3]

Denials Based on Medical Necessity or Experimental Treatment

If a benefit denial is based on a medical necessity or experimental treatment or similar exclusion or limit, the claims fiduciary must provide 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 the explanation will be provided free of charge upon request.[4]

Access to Claim Files and Plan Benefit Determination Guidelines and Protocols

All benefit denial notices (initial denial notices and denial notices on appeal)[5] must include:

- the internal rules, guidelines, protocols, standards or other similar criteria (if any) used in denying a claim, or a statement that none were used, even if the claimant does not request them; [6] and

- 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. [7]

Non-English Language Requirements

Required notices and disclosures must be written in a culturally and linguistically appropriate manner. Specifically, if a claimant's address is in a county where 10 percent or more of the population residing in that county are literate only in the same non-English language, denial notices must include a statement prominently displayed in the applicable non-English language clearly indicating how to access language services provided by the plan. In addition, plans must provide a customer assistance process (such as a telephone hotline) with oral language services in the non-English language and provide written notices in the non-English language upon request. [8]

The Right to Review and Respond to New Evidence or Rationale

A claims fiduciary must provide the claimant with any new or additional evidence considered, relied upon or generated by the claims fiduciary in connection with an appeal before the plan can issue a benefit denial on appeal. The new or additional evidence must be provided as soon as possible and sufficiently in advance of the due date of the appeal decision to afford the claimant a reasonable opportunity to respond to the new information in advance of that date. The same requirement applies to any new or additional rationale in support of a denial.[9]

Contractual Filing Deadlines

Benefit denial notices must advise claimants of their right to bring an action under ERISA. The new regulations require the notice to describe any applicable contractual limitations period that applies to the claimant's right to bring the action, including the calendar date on which the contractual limitations period expires.[10] While courts have routinely held that contractual filing deadlines are not enforceable unless they are disclosed in benefit denial notices, the final rules explicitly require these provisions to be disclosed in claim denial notices associated with a disability claim.[11]

The "Deemed Exhaustion" Rule

If a plan fails to adhere to all the requirements in the claims procedure regulation, the claimant is deemed to have exhausted administrative remedies unless, among other requirements, the error was minor and nonprejudicial and other specified conditions are met. [12] Where the error is more substantial, a claimant is not required to exhaust the plan's claims procedure and may proceed immediately to federal court. If a claimant chooses to file suit, the regulations provide that the claimant's claim or appeal is deemed denied on review "without the exercise of discretion by an appropriate fiduciary." Thus, if a court were to determine that the error was not a minor error, the court might be inclined (in fact, might be required) to apply a de novo standard of review rather than the more plan-friendly arbitrary and capricious standard. If a claimant chooses to file suit, and a court finds that the violation was "minor," the court would remand the dispute to the claims fiduciary for determination on appeal.

Rescissions Treated as Benefit Denials

Rescissions of disability coverage must be adjudicated in accordance with the new claims rules even if there is no adverse effect on any particular benefit at the time the coverage is rescinded.[13] The term "rescission" means a cancellation or discontinuance of coverage that has retroactive effect except to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of

coverage. So, for example, a retroactive termination due to an alleged misrepresentation of fact in an application for coverage is treated as a benefit denial that would be subject to review in accordance with the plan's appeal procedures.

Next Steps for Employers

- **Identify Impacted ERISA Plans and "Arrangements"**

  Impacted plans could include insured and self-insured short-term disability plans; long-term disability plans; health and welfare benefit plans; profit sharing, 401(k), and 403(b) plans; employee stock ownership plans; and defined benefit pension plans.

  Employers should not overlook employment agreements, annual and long-term incentive plans, severance plans, equity compensation arrangements, and nonqualified deferred compensation arrangements, whether they cover one employee or many.

  The essential questions are these: Is the plan or arrangement covered by ERISA? If so, does the plan or arrangement condition the availability of a right or benefit on a finding of disability? If so, is the disability determination made by a party other than the plan?

  Plan Design

  If a plan fiduciary has the authority and related duty to make a disability determination under a covered plan, consider adopting a plan amendment that would remove the discretion (i.e., that would incorporate a disability determination made by a third party under another plan).

- **Identify and Document Contractual Claim Filing Deadlines and Forum Selection Clauses**

  Claims fiduciaries will need to identify any contractual filing provisions in plan documents, insurance policies and summary plan descriptions and take steps to ensure that these deadlines are clearly and accurately communicated as part of the claims process. While not required by the regulations, conservative employers will want to ensure that claim denial letters apprise claimants of any plan provisions that limit ERISA's venue choices.

- **Review Service Agreements With Insurers and Third-Party Administrators**

  Employers should obtain assurances from insurers and third-party administrators that they are prepared to administer claims in accordance with the new rules. Service agreements should be reviewed and, if necessary, updated to address these responsibilities. Service agreements should also be reviewed and, if necessary, amended to address liability for failure to comply.

- **Amend Plan Documents, Summary Plan Descriptions and Claims Procedures**

  Plan documents, summary plan descriptions, and existing claims procedures need to be reviewed and, if necessary, updated to reflect the new rules.

- **Training**

  Employees and committees that have claim adjudication responsibilities should be trained on the new rules.

- **Conflict Avoidance**

  Establish guidelines that govern the employment of individuals with claims adjudication responsibilities to ensure that the claims process is free of any potential conflicts of interest

---

Arthur A. Marrapese III is a partner at Barclay Damon LLP in Buffalo, New York. He helps plan sponsors and fiduciaries identify, prioritize and minimize the litigation and liability risks associated with the management and administration of employee benefit programs.

[1] The Second Circuit has adopted a "strict" compliance standard similar to the standard imposed by the new disability claims regulations. See Halo v. Yale Health Plan, 819 F.3d 42 (2nd Cir. 2016) (ruling that a plan's failure to comply with the DOL's claims procedure regulations will be reviewed de novo in federal court unless the claims fiduciary can demonstrate that the failure to comply was inadvertent and harmless).

[2] 29 C.F.R. § 2560.503-1(b)(7).

[3] 29 C.F.R. § 2560.503-1(g)(1)(vii)(A).

[4] 29 C.F.R. § 2560.503-1(g)(1)(vii)(B).

[5] Under the existing rule, this statement is required only in notices denying benefits on appeal.

[6] 29 C.F.R. § 2560.503-1(g)(1)(vii)(C) and 29 C.F.R. § 2560.503-1(j)(6)(iiii). Under the existing rule, rules or protocols are available to a claimant but only upon request.

[7] 29 C.F.R. § 2560.503-1(g)(1)(vii)(D) and 29 C.F.R. § 2560.503-1(j)(3).

[8] 29 C.F.R. § 2560.503-1(g)(1)(viii).

[9] 29 C.F.R. § 2560.503-1(h)(4)(i) and (ii).

[10] The U.S. Supreme Court has held that ERISA does not prohibit reasonable contractual limitations periods for benefit claims. See Heimeshoff v. Hartford Life & Accident Ins. Co., 134 S. Ct. 604, 611 (2013).

[11] 29 C.F.R. § 2560.503-1(j)(4)(ii).

[12] 29 C.F.R. § 2560.503-1(l)(2).

[13] 29 C.F.R. § 2560.503-1(m)(4)(ii).