CLIENT ALERTS & INSIGHTS

New Final Claims Regulations Regarding Disability-Related Claims Has Been Issued by DOL

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On December 16, 2016, the U.S. Department of Labor (DOL) published a final rule altering the claims procedure regulations for ERISA plans providing disability benefits (the "Final Rule"). The regulations, which finalize proposed regulations issued in November 2015, amend the existing DOL claims procedure regulations related to any ERISA disability benefit claim, whether the claim arises under a welfare plan (*e.g.,* a long-term or short-term disability plan), or a qualified retirement plan.

According to a summary issued by the DOL, the Final Rules are "substantially the same" as the proposed regulations, however, as discussed below, there are some notable exceptions. The Final Rule will apply to claims for disability benefits filed on or after January 1, 2018. Thus, disability plans have almost a year to implement any changes to conform the operations of their claims review procedure with the new requirements imposed under the Final Rule.

In general, the Final Rule states that administrators of disability plans: (i) must provide more detail in adverse benefit decision letters (for both initial claim letters and appeal denial letters); (ii) adopt certain additional criteria to ensure independence and impartiality in the decision-making process; (iii) treat most rescissions as adverse benefit determinations; (iv) allow claimants to go directly to court if the claims procedures of the plan does not strictly comply with the requirements of the Final Rule; and (v) make disability claims subject to the same "culturally and linguistically appropriate" rules as group health plan claims.

The below summary sets forth both the key provisions that have been carried forward from the proposed regulations and highlights some of the changes included in the Final Rule:

(1) Avoiding Conflicts of Interest/Impartiality. Under the proposed rule, the DOL expanded the scope of the conflict of interest rules by providing new criteria for avoiding conflicts of interest and ensuring the impartiality of individuals involved with the claims review process. These requirements have been adopted in the Final Rule. Specifically, the new criteria require that:

- 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.

One of the significant changes made to the conflict of interest provisions in the Final Rule is the expansion of the list of persons deemed to be involved in the decision-making process who must be

insulated from a conflict of interest. Under the proposed rule, the individuals involved in the decision-making process included the claims adjudicator (such as the members of a review committee), and the medical experts who conducted any peer reviews. Under the Final Rule, the DOL has added vocational experts to the examples of persons deemed to be involved in the decision-making process.

In addition, the Preamble to the Final Rule clarifies that the conflict of interest/impartiality requirements apply even if an ERISA plan does not directly hire or compensate the individuals involved in making claim determinations. Thus, the Final Rule:

- Is not limited to individuals that the plan directly hires; and
- Includes individuals hired or compensated by third parties engaged by the plan regarding the administration of disability claims.

For example, if a service provider to a disability plan is in charge of hiring, compensating, terminating, or promoting an individual involved in claims decision-making, the administrator of the disability plan must take steps (for example, through the terms of its service contract or ongoing monitoring) to ensure that the service provider's policies, practices, and decisions regarding hiring, compensating, terminating, or promoting covered individuals are not based on the likelihood that the individual will support the benefit denial decisions.

(2) Expanded Disclosure Requirements. The proposed rule required disability plans to provide the following three (3) additional pieces of information in any disability denial letter, including both the initial denial letter and appeal denial letter:

- A discussion regarding the basis for disagreeing with the opinions rendered by any treating physician who granted a similar claim as submitted by claimant, including any disability finding as made by the Social Security Administration (SSA);
- The specific internal rule, guideline, protocol, standard, or other similar criterion relied upon in making the adverse determination; 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 claim (previously, this statement was only required for adverse determinations at the appeals stage).

These above requirements remain generally unchanged in the Final Rule. Notably, however, the Final Rule adds two (2) key requirements:

- All denial letters must address the basis for disagreement with advice obtained on behalf of the plan from any medical and/or vocational experts, regardless of whether the advice was relied on in making the benefit determination; and

- Each appeal denial letter must describe any plan-imposed deadline for filing a lawsuit and the applicable expiration date related to the claimant’s denied claim.

(3) Right to Review and Respond to New Information Before Final Decision on Appeal. The proposed regulations also added additional requirements related to right to review and respond to any new or additional evidence or rationales developed by a plan during the pendency of a disability appeal. These provisions were basically unaltered by the Final Rule. Thus, under the Final Rule, a disability plan is required to:

- Provide free of charge, prior to a plan's decision on appeal, any new or additional evidence or rationale considered, relied upon, or generated by the plan in connection with the disability claim. This information must be provided as soon as possible and in advance of the plan's decision on appeal in order to give the claimant a reasonable opportunity to respond to such new or additional evidence;
- Consider any response from the claimant, and if the claimant's response caused the plan to generate another medical report containing new evidence, the plan would have to automatically furnish to the claimant any new evidence in the new report; and
- The evidence from the new report would have to be furnished as soon as possible and sufficiently in advance of the current claims appeal deadline.

The Final Rule did clarify certain aspects related to the extent of review rights granted to claimants. According to the DOL, claimants will be deemed to be deprived of their right to a full and fair review when they are prevented from responding to evidence and rationales at the administrative claims level. In the Preamble to the Final Rule, the DOL dismissed concerns raised in several comments that this provision could result in an endless loop of submissions to the plan.

Further, the DOL noted that the administrator of disability plans may not satisfy the new review and response requirements:

- Through a process of offering claimants a voluntary opportunity to appeal any rationale raised for the first time in an appeal denial letter; or
- By providing claimants a notice informing them that the plan relied on new or additional evidence (or a new or additional rationale) in denying the claim, and offering to provide the new evidence or rationale on request.

Instead, the administrator of a disability plan must send the new or additional evidence or rationale automatically to the claimant as soon as it becomes available to the plan.

(4) Deemed Exhaustion of Claims Appeal Process. The proposed regulations also set forth certain revisions to the deemed exhaustion provisions as currently set forth under the existing DOL claims review regulations. The changes as set forth in the proposed regulations have basically been fully adopted by the Final Rule. Thus, after the 2018 effective date, the following changes will apply with respect to the disability claims review process:

- If the plan failed to strictly adhere to the rules for processing initial disability claims and appeals, a claimant would be deemed to have exhausted the administrative procedures under the plan and will be entitled to sue under a de novo standard of review, unless the so-called "minor errors exception" applied.

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  - Minor Errors Exception. The Minor Errors Exception would provide that any violation of the DOL claims review regulations would permit a claimant to seek immediate court action, unless the violation was: (i) de minimis; (ii) non-prejudicial; (iii) attributable to good cause or matters beyond the plan's control; (iv) in the context of an ongoing good-faith exchange of information; **and** (v) not reflective of a pattern or practice of non-compliance

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  - In addition, the claimant would be entitled, upon request, to an explanation of the plan's basis for asserting that it meets this standard, so that claimant could make an informed judgment about whether to seek immediate judicial review.

- In those situations, when the Minor Errors Exception does 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. Thus, the claimant would go back to where he stood prior to seek court intervention because of the alleged procedural violation.

(5) Coverage Rescissions. The proposed regulations 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. The change made in this context by the proposed regulations was adopted without change by the Final Rule.

(6) Linguistically Appropriate Denial Letters. The proposed regulations also included an obligation that, in certain situations, any adverse benefit decision must be provided in a "culturally and linguistically appropriate manner." This obligation has been adopted unchanged by the Final Rule. Thus, under the Final Rule, if a claimant's address is in a county where 10% or more of the population (as determined by the US Census Bureau) are "literate only in the same non-English language," notices of an adverse benefit determination must include a prominent one-sentence statement in the relevant non-English language about the availability of language services. Further, the Final Rule states that Plan will be required to "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."

Conclusion

The implementation of the Final Rule will require disability plan administrators to navigate several new obstacles, and any failure to successfully negotiate all of these additional responsibilities will likely lead to increased litigation, along with the loss of the deferential standard of review. Fortunately, the Final Rule applies to claims initially filed on or after January 1, 2018. Thus, plan administrators will have almost a year to modify their processes and procedures in order to bring their plans into compliance with the Final Rule.

For more information on this topic, please contact a member of Benesch's Labor & Employment Practice Group.

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