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DOL Proposes More Stringent Rules for Disability Claims Procedures

The DOL has proposed regulations that will change the procedures ERISA plans must follow in adjudicating claims for benefits conditioned on a determination of disability, including claims for disability retirement benefits. The proposed rules generally adopt the expanded internal claims and review requirements that apply to non-grandfathered group health plans under ACA guidance, with some limited modifications and additions.

Background

ERISA prescribes the procedures that employee benefit plans subject to ERISA must follow in adjudicating and administering benefit claims and appeals. These rules generally apply to all benefits subject to ERISA, although there are some differences depending on the type of benefit — for example, the timeframes for adjudicating claims or appeals are shorter for health and disability benefits than they are for claims involving life insurance or pension benefits.

Citing the increase in disability benefit litigation and the aggressive stance taken by insurers and plans in disputing disability claims, the DOL recently proposed new regulations intended to “strengthen the procedural rules governing the adjudication of disability benefit claims.” The proposed rules generally adopt the additional claims and appeals requirements applicable to non-grandfathered group health plans under the Affordable Care Act (ACA rules).

Proposed Regulations

Published on November, 18, 2015, the proposed regulations generally require ERISA plans to satisfy the following additional procedural requirements when they adjudicate a claim for a benefit conditioned on a finding of disability.

What benefits are subject to proposed rules?

A benefit is subject to the special rules for disability claims if the claims adjudicator must make a determination of disability in order to decide the claim. This includes claims for:

- Short-term and long-term disability benefits
- Waivers of premium under a life insurance policy
- Disability retirement benefits

The special disability rules do not apply if the finding of disability was made by a third party for a purpose unrelated to making a benefit determination under the plan. For example, if a pension plan conditions eligibility for disability retirement benefits on a prior determination of disability by the Social Security Administration or by the employer’s long-term disability plan, the claim would be subject to ERISA’s rules for pension claims rather than disability claims.

Expanded Definition of Adverse Benefit Determination

ERISA's rules govern claimants' appeals of adverse benefit determinations (see text box). Under the proposed regulations, "adverse benefit determination" also includes any rescission of disability *coverage*, even if there is no adverse effect on any particular benefit at the time. For this purpose, "rescission" means a cancellation or discontinuation of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions.

> **Comment.** The ACA prohibits a group health plan or insurer from rescinding medical coverage except in cases of fraud or a misrepresentation of a material fact. The proposed rules do not include a similar prohibition for disability coverage; they simply provide that a rescission of disability coverage is subject to the ERISA's claims procedures for disability plans.

Adverse Benefit Determination

An "adverse benefit determination" means a denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including denials, reductions or terminations based upon a determination that a participant or beneficiary is not eligible to participate.

Additional Notice Requirements

ERISA requires all plans to provide claimants with notice of any adverse benefit determination, both at the initial claim level and after an appeal. Under the proposed rules, plans that provide disability benefits would be required to include the following additional disclosures in those notices:

Basis for disagreement with third party's determination that claimant is disabled. The notice must include a discussion of the disability determination. If the plan did not accept a disability determination made by the claimant's treating physician or by another third party payer of disability benefits, such as the Social Security Administration or an insurer, the notice of adverse benefit determination must set out the basis for the plan's disagreement with the third party's determination.

Information about criteria used by plan in making its determination. The notice must contain the internal rules, guidelines, protocols, standards or other similar criteria on which the plan relied in denying the claim or include a statement that they do not exist.

Statement of claimant's right to receive relevant documents upon request. The notice must include 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 his or her claim for disability benefits.

> **Comment.** Under current ERISA regulations, this statement is required only in notices following the denial of an appeal. The proposed regulations extend the requirement to initial claim determinations.

What are the required non-English languages?

Each year the U.S. Census Bureau publishes a list of those counties in which at least 10% of all residents are literate in the same non-English language. For 2015, the applicable languages are as follows:

- Chinese (required only for San Francisco County, California)
- Tagalog (required only for two counties in Alaska)
- Navajo (required for Apache County, Arizona)
- Spanish (required for counties in 21 states and Puerto Rico)

Culturally and Linguistically Appropriate Notices. The proposed regulations require a plan to provide communications in a non-English language to claimants whose address is in a United States county that has been identified by the Census Bureau as having 10% or more of its population literate only in the same non-English language. A plan that has participants residing in such a county must have a customer assistance process (such as a telephone hotline) with oral language services available to answer questions and provide assistance in filing claims and appeals in the applicable non-English language. Notices related to claims and appeals decisions addressed to claimants residing in the county must contain a one-sentence notice in the applicable language about the availability of language assistance, and the plan must provide notices in the language upon request.

Additional Measures to Ensure Full and Fair Review

The various requirements set out in the current ERISA claims regulations are intended to ensure that claimants receive a full and fair review of their benefits claims and appeals. The proposed regulations provide that in addition to complying with current ERISA requirements relating to a full and fair review upon appeal, the claims procedures of a plan providing disability benefits must also:

Allow a claimant to review the claim file and present evidence and testimony as part of the claims and appeals process. The preamble to the proposed regulations notes that this requirement contemplates the submission of written evidence and testimony and does not entitle the claimant to an oral hearing.

Provide the claimant with an opportunity to respond to any new evidence or rationale that the plan relied on in making an adverse benefit determination on review before the decision is issued. The proposed regulations require the plan administrator to provide the claimant, prior to issuing any adverse benefit determination on review, with any new evidence considered, relied on or generated by the plan during the appeals process. Similarly, before a plan can issue an adverse benefit determination on review based on a new or additional rationale, the plan administrator must provide the claimant with that rationale. The new evidence or rationale must be provided without charge and sufficiently in advance of the date on which the plan is required to issue the notice of adverse benefit determination on review so that the claimant has a reasonable opportunity to respond.

Comments Welcome

The proposed regulations also include a request for comments on whether final regulations should require a plan to include a statement about any contractual limitation period for bringing a lawsuit in any notice of adverse benefit determination on appeal and to provide an updated notice of the deadline if tolling or some other event causes that deadline to change.

Be designed to avoid conflicts of interest. Claims and appeals involving disability benefits must be adjudicated in a manner that ensures the independence and impartiality of the persons involved in making the decision. To that end, the proposed regulations specify that decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to a claims adjudicator or medical expert cannot be based upon the likelihood such individual will deny a claim for disability benefits.

New Rules Regarding Deemed Exhaustion of Administrative Remedies

Generally, a claimant cannot bring a lawsuit seeking benefits under an ERISA plan unless he or she has exhausted all "administrative remedies" (i.e., the plan's claims procedures). The proposed regulations generally adopt the rules regarding deemed exhaustion of administrative remedies set out in the ACA claims regulations. They provide that if a plan violates any applicable ERISA requirement in handling a disability claim, a claimant will be deemed to have exhausted administrative remedies and may immediately file suit unless the plan's violation was:

- De minimis;
- Non-prejudicial or non-harmful;
- For good cause or because of matters beyond the plan's control;
- In the context of an on-going, good-faith exchange of information; and
- Not a pattern or practice of non-compliance.

If all of these conditions are met, there will be no deemed exhaustion of remedies and legal action will be premature.

A claimant may request a written explanation from the plan regarding a violation, to which the plan must respond within 10 days. If the plan asserts that the exception for "de minimis" violations applies, the explanation must set out the bases for the plan's assertion.

The proposed rules include what the DOL characterizes as a "special safeguard" for a claimant whose request for an immediate review is rejected by the court on the basis that the exception for "de minimis" violations applies. Under this "special safeguard," the plan must treat a claimant's appeal as refiled as of the date it receives notice of the court's decision and provide the claimant with notice of the resubmission. The resubmitted appeal would be subject the applicable timeframes and other rules regarding submission of evidence and testimony would apply.

What are the timeframes for deciding disability claims and appeals?

The plan must decide claims and appeals within a reasonable period, taking into account all circumstances. With the exception of the time limit for filing an appeal, the timeframes below reflect the maximum period by which a plan must make a determination:

Decision on initial claim: 45 days after submission; additional 30 days with prior notice for circumstances beyond control of the plan

Decision on appeal: 45 days after receipt of appeal; additional 45 days with prior notice for "special circumstances"

A special deadline for deciding appeals applies when the named fiduciary is a board or committee that meets at least quarterly. Per a technical correction in the proposed regulations, this special deadline is only available to multiemployer plans.

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DOL's View of Impact

"The Department expects the proposed regulations would impose modest costs on disability benefit plans, because many plans already are familiar with the rules that would apply to disability benefit claims due to their current application to group health plans."

Effective Date

The new rules for disability benefits would become effective 60 days after the date final rules are published in the Federal Register.

In Closing

The DOL's importation of the ACA claims and appeals rules into the ERISA claims regulations is not unexpected. The DOL's optimism notwithstanding (see text box), most plans providing disability benefits will have to significantly revamp their procedures in order to comply with the new requirements.

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