PUBLICATION

U.S. Department of Labor Issues More Stringent Regulations for the Review of Disability Benefit Claims

Authors: Martha L. Boyd
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The Department of Labor (DOL) published the Final Rule on December 19, 2016, revising the regulations addressing claims procedures for ERISA plans providing disability benefits. These claims procedures were developed pursuant to Section 503 of ERISA, which requires every employee benefit plan 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." The original regulations were published in 1977 and revised in 2000. The DOL used the changes imposed on group health plans by the Affordable Care Act (ACA) as a model for the rule changes for disability plans, and the Final Rule brings some of the protections currently applicable to claims for group health benefits under the ACA to disability claims. The new regulations apply to claims for disability benefits filed on or after January 1, 2018.

In the preamble to the Final Rule, the DOL provided a summary of the requirements of the Final Rule that, in some respects, appear no different than the requirements of the current rule. The DOL explained that the major provisions of the Final Rule require that:

(1) claims and appeals must be adjudicated in a manner designed to ensure independence and impartiality of the persons involved in making the benefit determination;

(2) benefit denial notices must contain a complete discussion of why the plan denied the claim and the standards applied in reaching the decision, including the basis for disagreeing with the views of health care professionals, vocational professionals or with disability benefit determinations by the Social Security Administration (SSA);

(3) claimants must be given timely notice of their right to access to their entire claim file and other relevant documents and be guaranteed the right to present evidence and testimony in support of their claim during the review process;

(4) claimants must be given notice and a fair opportunity to respond before denials at the appeals stage are based on new or additional evidence or rationales;

(5) plans cannot prohibit a claimant from seeking court review of a claim denial based on a failure to exhaust administrative remedies under the plan if the plan failed to comply with the claims procedure requirements unless the violation was the result of a minor error;

(6) certain rescissions of coverage are to be treated as adverse benefit determinations triggering the plan's appeals procedures; and

(7) required notices and disclosures issued under the claims procedure regulation must be written in a culturally and linguistically appropriate manner.

Preamble pp. 11 – 12. Each of these major changes is discussed below.

No Bias:
In order to reduce the likelihood of inappropriate benefit denials, the final regulations require independent and impartial individuals to determine disability claims and appeals. Specifically, the Final Rule prohibits decisions about hiring, compensation, termination, promotion or other similar actions with respect to any individual from being made based upon the likelihood that the individual will support the adverse benefit determination. Preamble p. 14, § 2560.503-1(b)(7). The DOL acknowledged that this requirement existed previously, if not by law then by practice, since many disability plans and other fiduciaries already had taken steps to ensure the independence and impartiality of the individuals involved in making claims determinations.

Note that the DOL takes the position that vocational experts fall into this category of individuals who must be insulated from the adjudicating party's or issuer's conflicts of interest and specifically included them in the text of the Final Rule.

Disclosure Requirements:
The Final Rule requires a full discussion of all of the reasons related to a denial of a benefit claim. Along these lines, a "full discussion" requires an explanation of the basis for disagreeing with the views of treating health care professionals and vocational professionals who evaluated the claimant. See § 2560.503-1(g)(1)(vii)(A)(i). The DOL also requires an explanation of the basis for disagreeing with experts that the party adjudicating the benefit claim itself consulted. See § 2560.503-1(g)(1)(vii)(A)(ii). In other words, if the party adjudicating a benefit claim consults with three medical experts, and one of those experts concludes that the claimant is disabled, the adjudicating party is required to disclose the identity and opinion of that expert and why the ultimate disability determination deviated from that opinion, even if the adjudicating party did not "rely" on that expert's opinion.

The party adjudicating the benefit claim also is required to explain the basis for disagreement with or failure to follow disability determinations by the SSA. See § 2560.503-1(g)(1)(vii)(A)(iii). The DOL adopted this requirement over objections by some commenters that it does not make sense to require an ERISA plan fiduciary to make a judgment about a disability determination made by a plan or program that may have a different or inconsistent definition of disability, particularly since the plan fiduciary may be unable to get the documents or case file necessary to make such an evaluation. The DOL rejected these objections with respect to SSA opinions, noting that SSA determinations often include a written decision from an administrative law judge, and the definitions and presumptions are contained in SSA guidance and regulations, which are publicly-available. Accordingly, the notice of an adverse benefit determination must include a discussion of the basis for disagreement with an SSA disability determination that the claimant submits to the plan (the language states "[a] disability determination regarding the claimant presented by the claimant to the plan made by the Social Security Administration"). This language implies that the plan is not required to affirmatively seek out the SSA information. Significantly, the DOL explained that "[i]t also would not be sufficient for the benefit determination merely to include boilerplate text about possible differences in applicable definitions, presumptions, or evidence," and that "[a] discussion of the actual differences" is required. A more robust explanation is required where the definitions of disability under the SSA and under the plan are "functionally equivalent."

The Final Rule adds a provision that requires the party adjudicating a benefit claim to explain an adverse benefit determination "based on a medical necessity or experimental treatment or similar exclusion or limit" or inform the claimant that such an explanation will be provided free of charge upon request." See § 2560.503-1 (g)(1)(vii)(B).

The Final Rule also requires that the "internal rules, guidelines, protocols, standards or other similar criteria that the party adjudicating the benefit claim relied upon in making an adverse benefit determination" must be provided with the adverse benefit determination. See § 2560.503-1(g)(1)(vii)(C). If the party adjudicating the benefit claim did not rely on any rule or guideline, it must include a statement to this effect in the notice of adverse benefit determination. See § 2560.503-1(g)(1)(vii)(C).

The Final Rule adds a requirement that notice of an adverse benefit determination at the initial claims stage must include a statement that the claimant is entitled to receive, upon request and free of charge, all documents, records and other information relevant to the claim for benefits. See § 2560.503-1(g)(1)(vii)(D). Under the current rule, such a statement is required only in notices of an adverse benefit determination upon appeal.

Right to Review:

The Final Rule provides that claimants have a right to review and to respond to new or additional evidence or rationales considered by the party adjudicating a claim during the pendency of the appeal, and not merely after the appeal has been denied. § 2560.503-1(h)(4)(i) and (ii). This evidence or rationale must be provided as soon as possible, sufficiently in advance of the date on which the notice of adverse benefit determination must be provided, in order to give the claimant a reasonable opportunity to address the information before that date.

An example in the preamble describes how this should work:

[A]ssume the plan denies a claim at the initial stage based on a medical report generated by the plan administrator. Also assume the claimant appeals the adverse benefit determination and, during the 45-day period the plan has to make its decision on appeal, the plan administrator causes a new medical report to be generated. The proposal and the final rule would require the plan to automatically furnish to the claimant any new or additional evidence in the second report. . . . The plan would have to furnish the new or additional evidence to the claimant before the expiration of the 45-day period.

Preamble p. 33. The preamble goes on to say that if the claimant's response to this new information causes the party adjudicating the benefit claim to generate yet another medical report containing new or additional evidence, it would be required to furnish this information to the claimant, too. On the other hand, if the claimant's response objects to or disagrees with the rationale but does not include new factual information or medical diagnoses, the party adjudicating the benefit claim is not required to generate another report and may instead rely on what it already has. Preamble pp. 36 – 37. Note, too, that the DOL did not extend the period the party adjudicating the benefit claim has to provide a notice of final adverse benefit determination to allow the claimant with a reasonable opportunity to respond to the new or additional information. The DOL explained that the party adjudicating a benefit claim already has the ability to take an extension at the appeals stage pursuant to the "special circumstances" provision in the current rule.

Deemed Exhaustion:

The Final Rule provides that if the party adjudicating the benefit claim fails to adhere to all the requirements in the claims procedure regulation, the claimant will be deemed to have exhausted administrative remedies, except in circumstances where the violation was: (1) de minimis; (2) non-prejudicial; (3) attributable to good cause or matters beyond the control of the party adjudicating the benefit claim; (4) "in the context of an ongoing good-faith exchange of information;" or (5) not reflective of a pattern or practice of non-compliance. §§ 2560.503-1(l)(1) and (2). This is a significant change from the "substantial compliance" standard which is employed under the current rule. Preamble p. 42. Although the DOL declined to articulate a rule changing the level of deference that a reviewing court may give a fiduciary's decision in a case where the claim is deemed denied, the DOL noted that a court may conclude that de novo review is appropriate because of the lack of exercise of fiduciary discretion during the pendency of the claim. Preamble p. 44. Further, if a court rejects a

claimant's request for review because the party adjudicating the benefit claim met the standards for an exception to the "deemed exhausted" remedy, "the claim shall be considered as re-filed on appeal upon the adjudicating party's receipt of the decision of the court. Within a reasonable time after the receipt of the decision, the adjudicating party shall provide the claimant with notice of the resubmission." § 2560.503-1(2)(ii).

Coverage Rescissions Considered Adverse Benefit Determinations:

Paragraph (m)(4) of the Final Rule amends the definition of the term "adverse benefit determination" to include a rescission of disability benefit coverage that operates retroactively, except when the rescission is due to a failure to timely pay required premiums or contributions toward the cost of coverage. § 2560.503-1(m)(4)(ii). A rescission occurs whether or not there is an adverse effect on any particular benefit at the time. *Id*.

Culturally and Linguistically Appropriate Notices:

Paragraphs (g)(1)(vii)(C), (j)(7) and (o) of the Final Rule requires a party adjudicating a benefit claim to provide a notice of adverse benefit determinations to a claimant in a culturally and linguistically appropriate manner. This imposes two significant requirements:

[I]f a claimant's address is in a county where 10% or more of the population residing in that county are literate only in the same non-English language as determined in guidance based on American Community Survey data published by the United States Census Bureau, notices of adverse benefit determinations to the claimant would have to 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.

The U.S. Census Bureau has published a list of counties that meet the ten percent threshold. This list is available here.

The DOL noted in the preamble that this change to the Final Rule does not supersede the summary plan description foreign language rules in § 2520.102-2(c), which include a requirement to offer assistance, including language services, calculated to provide participants with a reasonable opportunity to become informed as to their rights and obligations under the plan.

Contractual Limitations Periods for Challenging Adverse Benefit Determinations:

The DOL also addresses several points regarding contractual limitations periods in the Final Rule. First, the DOL determined that a contractual limitations period that expired before the plan's internal appeals process was concluded would violate the requirement of a full and fair process set forth in ERISA Section 503. The Final Rule also includes a requirement that the notice of an adverse benefit determination on review must include a description of any applicable contractual limitations period and its expiration date for bringing a civil action related to an adverse benefit determination on appeal. See preamble pp. 54 – 55. The current rule does not require the inclusion of the date of the expiration of the contractual limitations period.

What Should You Do Next:

In order to comply with the increased duties and responsibilities imposed by the Final Rule, we suggest that plan administrators and appropriate fiduciaries (i) review current benefit claim procedures included in plan documents, summary plan descriptions, insurance policies and other instruments governing the plan to ensure compliance with the new regulations; (ii) adopt new disability claims procedures and distribute summaries of material modifications when appropriate; (iii) confirm that notices of adverse benefit determinations comply with the new regulations; and (iv) confirm that appropriate procedures have been adopted to ensure compliance with the non-English language requirements set forth in the Final Rule.