What Are They, What Is the Likely Fallout, and How Can You Prepare?

DOL's New Regulations for ERISA-Governed Disability Plans

By Amy L. Blaisdell

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The game is changing for ERISA-governed disability plans effective January 1, 2018, when new regulations issued by the United States Department of Labor (DOL) will go into effect. The regulations impose stringent new requirements on ERISA-governed disability plans. The DOL's rationale for the sweeping changes: a belief that the incidence of disability benefits litigation is too high, a concern about "aggressive denials" of disability benefit claims, a perception that conflicts of interest currently impair the objectivity and fairness of the claims process, concerns about some issues that participants and beneficiaries purportedly face when appealing a claim, and the desire to attempt to scale back the deferential review that plans currently receive.

Notably, the DOL may be unsuccessful in its attempts to scale back the deferential standard of review because the United States Supreme Court already decided in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), that trust law principles dictate that a denial of benefits challenged under section 1132(a)(1)(B) will be reviewed under a de novo standard unless the benefit plan expressly gives the plan administrator or the fiduciary discretionary authority to determine eligibility for benefits or to construe the plan's terms. If a plan administrator or fiduciary has such discretionary authority, the denial is to be reviewed under the abuse of discretion standard. *Id.* at 115.

What Is the Likely Fallout of the Amended Regulations?

The question is not will there be fallout from the new regulations, but rather, *what* will it be? There will be multiple consequences of the new regulations for plan sponsors, administrators, and insurers.

First, claims will be much more expensive to adjudicate because the DOL has taken the position that substantial compliance is no longer sufficient.

Second, despite the DOL's stated concern about the volume of disability plan litigation, the new regulations will only increase litigation.

Third, the new regulations incentivize plan participants to race to the courthouse to file their disability claims before the claims process has been completed, thereby entangling the federal courts in the claims adjudication process prematurely.

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Fourth, plan participants will likely assert more breach of fiduciary duty claims in litigation; the comments to the regulations refer repeatedly to the fiduciary duties owed by plan administrators, which supports inferring that these claims will increase.

Last, but by no means least, discovery battles will either become much more common and costly, or administrators and insurers will agree to certain discovery limits to curtail the cost of discovery battles.

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So Just What Are the Changes?

There are numerous changes to the existing disability claims regulations. The most significant changes concern alleged conflicts of interest, adverse determination letters, appeal process changes, and the so-called "deemed-exhausted" provision.

New Conflict of Interest Rules

First and foremost, to meet their obligation to establish and maintain reasonable claims procedures, plans must satisfy a new, additional requirement. The new regulations state:

> [T]he plan must ensure that all claims and appeals for disability benefits are adjudicated in a manner designed to ensure the independence and impartiality of persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to an 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.

29 C.F.R. §2560.503–1(b)(7).

Although this addition to the regulations is not exactly rocket science, it will likely require some process changes for most plans. Currently, most disability plan administrators take care to avoid and to document the absence of conflicts of interests among medical and vocational experts. However, the new regulations should prompt administrators and insurers to do more to ensure that they can establish a lack of bias or financial interest even for consultants who are retained by third parties.

Assume that an administrator uses a certain vendor to conduct independent medical reviews, functional capacity examinations, or vocational assessments, and that vendor in turn engages consultants to render opinions to the plan. The plan should implement steps to ensure the impartiality of the vendors retained by the third parties and should take care to document that impartiality in such a way that the impartiality later can be proved from the administrative record if a claim is litigated.

Denial Letters

The amended regulations also impose several new requirements for adverse benefit-determination notices for disability claims. Adverse benefit determination notices must now include:

> (A) A discussion of the decision, including an explanation of the basis for disagreeing with or not following: (i) The views presented by the claimant to the plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant; (ii) The views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (iii) A disability determination regarding the claimant presented by the claimant to the plan made by the Social Security Administration.
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> (B) Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making the determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist; and
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> (C) 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.

29 C.F.R. §2560.503—1(g)(1)(vii)(A)(C)(D).

The preceding requirements impose a massive burden on the claims adjudication process. For example, the requirement that a plan explain the basis for disagreeing or not following "any views" of any treating physician or vocational professional who examined a claimant is an exceptionally broad and burdensome requirement. This will require claims administrators to scour hundreds—if not thousands—of pages of medical treatment and vocational assessment records to identify and to explain each and every "view" with which they disagree.

This is not practical, or even possible, in most cases, and it is directly contrary to one of Congress' goals in enacting ERISA, which was "to create a system that is [not] so complex that administrative costs, or litigation expenses, unduly discourage employers from offering [ERISA] plans in the first place." *Conkright v. Frommert*, 559 U.S. 506, 517 (2010) (quoting *Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996)). This new requirement also means that plan administrators will have to waste resources that could be better spent paying valid claims, since disability plans have no obligation to defer to the views of the treating physician anyway. *Black & Decker v. Nord*, 538 U.S. 822 (2003).

The DOL also reiterated in the comments to the regulations that it intends to view broadly the requirement that disability plans explain the basis for disagreeing with a determination made by the Social Security Administration. The DOL notes that although a plan's claim procedures may place the burden on a claimant to submit any Social Security Administration determination that the claimant wants the plan to consider, "claims administrators working with an apparently deficient administrative record must inform claimants of the alleged deficiency and provide them with an opportunity to resolve the stated problem

by furnishing the missing information." 81 Fed. Reg. 243,92322 (Dec. 19, 2016).

Appeal Changes

The amended regulations also include huge changes for the appeals process by requiring notification to a participant *before* an adverse determination is rendered on appeal under two circumstances. Before a plan can issue an adverse determination on review, the plan must provide the following information to a claimant, free of charge:

a. any new or additional evidence considered, relied upon, or generated by the Plan, insurer, or other person making the benefit determination (or at the direction of the planinsurer or such other person) in connection with the claim; and
b. any new or additional rationale for the adverse benefit determination.

29 C.F.R. §2560.501—1(h)(4)(i)-(ii).

The evidence or new or additional rationale must be provided free of charge, as soon as possible, and sufficiently in advance of the date on which the notice of adverse benefit determination on review is due, to give a claimant a reasonable opportunity to respond before that date. *Id.* Once again, the regulations state that the terms "new or additional evidence" and "new or additional rationale" are to be construed broadly. These requirements will result in a lengthy tennis match between claimants appealing benefit denials and the claim administrators.

Deemed Exhausted

The provision of the new regulations that will prompt the race to the courthouse is the "deemed-exhausted" rule. *See* 29 C.F.R. 2560.503–1(l)(2). Under the new regulations, if a plan fails to "strictly adhere" to "all" requirements in the claims procedure regulations, "the claimant is deemed to have exhausted the administrative remedies available under the plan," with a limited exception. *See* 29 C.F.R. 2560.503–1(l)(2)(i).

> The limited exception is for de minimis violations that do not cause, and are not likely to cause, prejudice or harm to the claimant so long as the plan demonstrates that the violation was for good cause or due to maters beyond the control of the plan and that the violation occurred in the context of an ongoing, good faith exchange of information between the plan and the claimant. This exception is not available if the violation is part of a pattern or practice of violations by the plan.

See 29 C.F.R. 2560.503–1(l)(2)(ii).

> Additionally, [t]he claimant may request a written explanation of the violation from the plan, and the plan must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the administrative remedies under the plan to be deemed exhausted. If a court rejects the claimant's request for immediate review … on the basis that the plan met the standards for the exception under this paragraph … the claim shall be considered as re-filed on appeal upon the receipt of the decision of the court. Within a reasonable time after the receipt of the decision, the plan shall provide the claimant with notice of the resubmission.

See 29 C.F.R. 2560.503–1(l)(2)(ii).

Absent application of the exception, the new regulations state that a claimant is entitled to pursue any available remedies under section 502(a) of the act "on the basis that the plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim." The amended regulations further state that, "if a claimant chooses to pursue remedies under Section 502(a) of the Act under such circumstances, the claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary." *See* 29 C.F.R. 2560.503–1(l)(2)(i).

The DOL notes that this rule is more stringent than a "strict compliance" standard. Although there have been many commentaries surmising that this means that a de novo standard will be applied by a court, the DOL notes in its comments that it is not deciding that a de novo review is to be applied by the court:

> The Department does not intend to establish a general rule regarding the level of deference that a reviewing court may choose to give a fiduciary's decision interpreting benefit provisions in the plan's governing documents. However, the cases reviewing a plan fiduciary's decision under a deferential arbitrary or capricious standard are based on the idea that the plan documents give the fiduciary discretionary authority to interpret the plan documents. By providing that the claim is deemed denied without the exercise of fiduciary discretion, the regulation… is intended to define what constitutes a denial of a claim. The legal effect of the definition may be that a court would conclude that de novo review is appropriate because of the regulation that determines as a matter of law that no fiduciary discretion was exercised in denying the claim.

In other words, the DOL deals with the Supreme Court's *Firestone* precedent by stating that it is doing so in the context of what it means to deny a claim. That explanation is somewhat suspect given that the change does not appear in the definitional section of the regulation. It will be incumbent upon defense counsel to explain to federal district courts that it is fundamental to the claims process that a claims administrator is permitted to complete the review of a claim and issue a decision so that a court can then review that decision. Doing otherwise runs completely contrary to the goals of ERISA and jeopardizes the existence of voluntarily provided disability plans.

Contractual Limitations Periods

The amended regulations specify that in addition to including the statement of a claimant's right to bring an action under section 502(a) of the act, an adverse benefit determination "shall also describe any applicable contractual limitations period that applies to the claimant's right to bring such an action." 29 C.F.R. 503–1(j)(4)(ii). Furthermore, the notice must include the actual calendar date on which the deadline to file a lawsuit will expire. This requirement should prompt plan administrators to review their limitations periods to ensure that an event that causes the clock to begin running on the limitations period is easily identifiable and can be readily calculated by an administrator.

Notably, the DOL's comments also include some discussion about the length of time that a participant has to file suit. Specifically, the DOL notes that a limitations period that expires before the conclusion of a plan's internal appeals process on its face violates ERISA section 503's requirement of a full and fair review process. Therefore, plans should review their limitations peri-

ods to ensure that they give participants ample time to seek judicial review. Doing so will also help plans avoid the "deemed exhausted" requirement and will enable defense counsel to explain that the claims review process should be permitted to run its course, and the participant will not suffer any harm because there is ample time to seek judicial review once that process is complete.

Miscellaneous Provisions

The new regulations also include a few miscellaneous changes. They amend the definition of an adverse benefit determination to include a rescission of disability benefit coverage that has a retroactive effect, except to the extent that it is attributable to a failure to pay required premiums or contributions toward the cost of coverage timely. *See* 29 C.F.R. 2560.503–1(m)(4)(ii).

And they require plans to provide notice of an adverse benefit determination to claimants in a culturally and linguistically appropriate manner. This means that if a claimant's address is in a county where 10 percent or more of the population are literate solely in the same non-English language, as determined in guidance based on American Community Survey data pushed by the U.S. Census Bureau, notices of adverse benefit determinations to the claimant would have to include a statement prominently displayed in that non-English language that clearly indicates how to access language services provided by the plan. *See* 29 C.F.R. 2560.503–1(o).

What Can Disability Plans and Administrators Do Now?

There are many steps that plans can take now to help them prove absence of conflict, promote compliance with the new regulations, and avoid the possibility that courts will abandon the discretionary standard of review. Among those steps are the following.

Establish Absence of Conflicts

- Send a communication to all experts and consultants explaining the importance of impartiality and requiring an attestation that they are not compensated based on the manner in which they decide a claim. Maintain copies in the relevant claims file.
- Require diversity among the consultants used so that the same medical or other expert is not used routinely.
- Establish a process that documents proof of any expert's or consultant's qualifications, credentials, and in the claims file.

Update or Establish Processes

- Update or establish processes for weighing all the evidence before denying a claim and explaining the areas in which an administrator disagrees with the views of medical, vocational, and other experts in denying a claim, recognizing that "view" is interpreted broadly.
- Revise or establish new processes for informing a claimant when a Social Security award or other medical information is absent from a claims file and providing the claimant with an opportunity to furnish the missing information.
- Review or establish processes for ensuring that participants are informed of their right to access plan documents and other relevant information, recognizing that "relevance" will be interpreted broadly.
- Update or establish processes for responding to letters from participants demanding a written explanation of the reasons for alleged violations of plan procedures within 10 days of receipt of those letters.

Review and Revise Documents to Adhere to the Regulations and New Procedures

- Review and update any internal claims process manuals to comply with the new regulations and any new procedures.
- Ensure that initial denial letters and appeal determination letters are updated to include all required criteria.
- Amend plan documents to ensure that they mirror the required language set forth in the regulations.
- Review contractual limitations clauses to ensure that they are not so restrictive that they could be construed as denying a claimant the right to judicial review.
- Ensure that appeal determination letters inform participants of the limitations periods and the date on which the deadline to file suit will expire.
- Determine whether the plan has participants in counties where culturally language-specific notices are required, and if so, prepare language for denial letters so that they comply.

Train Claims Adjudicators

Claims adjudicators should receive training, or retraining, in these areas:

- The new regulations and any resulting process changes;
- The importance of near 100 percent compliance with the new regulations;
- The need for good and ongoing communications with plan participants to enhance the likelihood that any violations will be deemed de minimis;
- The need to avoid process delays and to explain any necessary delay to plan participants; and
- The importance of notetaking that will explain each and every step taken to adjudicate claims and ensure that a claimant will understand what information would result in approval of a claim.

Conclusion

In summary, the new regulations are coming, and there is much work to be done before January 1, 2018. However, with proper planning and an educated claims administrator and legal team, steps can be taken to protect the favorable standard of review and curb litigation costs.