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Department of Labor Issues Final Regulations on Disability Claims and Appeals Procedures

On December 16, 2016, the Department of Labor ("DOL") issued final regulations (the "Final Regulations") on claims and appeals procedures for plans that provide disability benefits. For the most part, the Final Regulations track procedural protections and safeguards afforded to participants in group health plans by the Affordable Care Act ("ACA"). However, the Final Regulations apply to all plans subject to the Employee Retirement Income Security Act ("ERISA") that provide disability benefits, including pension plans and all health and welfare plans (both grandfathered and non-grandfathered). Also, the Final Regulations are effective for disability claims filed on or after January 1, 2018, regardless of the plan year.

Final Regulations

The Final Regulations amend the DOL's current claims and appeals procedures for disability benefits, requiring plans, plan fiduciaries and insurance providers to comply with additional procedural protections for disability claims.[1] In the preamble to the proposed regulations, the DOL notes that it intends to "afford claimants of disability benefits a reasonable opportunity to pursue a full and fair review [. . .] that align[s] with the updated standards required by the [ACA]." The Final Regulations focus on six key areas:

1. procedural requirements to ensure independent and impartial review;
2. content requirements for notices of adverse benefit determination;
3. right to review and respond to new or additional information;
4. deemed exhaustion of claims and appeals processes;
5. treatment of most rescissions of disability coverage as adverse benefit determination; and
6. all notices must be provided in a culturally and linguistically appropriate manner.

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Independent and Impartial Review

Plans must ensure the independent and impartial review of all persons involved in the claims and appeals process. Specifically, plans may not make "decisions regarding hiring, compensation, termination, promotion, or similar matters" based on the likelihood that an individual will support the denial of disability benefits. Similarly, the preamble notes that plans may not contract with a medical expert based upon the expert's reputation for denying disability claims.

The Final Regulations added vocational experts to the list of individuals who must be insulated from conflicts of interest, which also includes claims adjudicators and medical experts. Also, the preamble notes that the independence and impartiality requirements are not limited to final decision makers, but also includes others who may support benefit denials.

Notice of Adverse Benefit Determination Requirements

Plans must include the following information as part of any notice of adverse benefit determination:

1. A discussion of the decision, including any basis for disagreeing with or not following a health care or vocational professional who treated or evaluated the claimant, a medical or vocational expert whose advice the Plan solicited, or a disability determination made by the Social Security Administration.

2. For claims involving medical necessity, experimental treatment, or similar exclusions, an explanation of the scientific or clinical judgment for the determination, applying the plan's terms to the claimant's medical circumstances or a statement that the claimant may receive such an explanation free of charge upon request.

3. Internal rules, guidelines, protocols, standards or other criteria used in denying the claim (or a statement that these do not exist).

4. 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 benefit claim.

Right to Review and Respond to New Information

Plans must allow claimants to review and respond to new or additional evidence or rationales developed by the plan during the pendency of an appeal. As in the ACA Final Rule, plans must provide a disability benefit claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by (or at the direction of) the plan in connection with the claim. Plans must also provide the claimant with any new or additional rationale for a benefit denial, and a reasonable opportunity to respond. Although the Final Regulations and preamble do not explicitly address the issue, the same analysis of what constitutes "new or additional evidence" or a "new or additional rationale" in the group health plan context likely applies in the disability context.

The DOL declined to include a special tolling rule for new or additional evidence in the Final Regulations. The ACA Final Rule provides that if new or additional evidence or rationale is received by a plan so late that it is impossible to provide the claimant a reasonable opportunity to respond, the period for providing a notice of final internal adverse benefit determination is tolled until the claimant has a reasonable opportunity to respond. In the preamble, the DOL noted that such a special tolling rule is unnecessary, as the current disability claims regulations already permit plans to take extensions at the appeals stage.

Deemed Exhaustion of Claims and Appeals Processes

If a plan fails to comply with the claims regulations, a claimant will be deemed to have exhausted administrative remedies unless the violation is (1) de minimis, (2) nonprejudicial, (3) attributable to good cause or matters beyond the plan's control, (4) in the context of an ongoing good-faith exchange of information, and (5) not reflective of a pattern of noncompliance. Also, upon request, claimants are entitled to an explanation of the plan's basis for asserting that it meets the minor errors exception.

Rescissions

Like the ACA Final Rule, the Final Regulations treat certain rescissions of coverage as adverse benefit determinations to trigger claim appeal rights. Under the Final Regulations, any "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" is a rescission. A rescission also triggers the claims review process.

Culturally and Linguistically Appropriate Notifications

Plans providing disability benefits must provide all notices in a "culturally and linguistically appropriate manner," which may include providing oral language services (such as a telephone customer assistance hotline), notices to participants in any applicable non-English language upon request, and statements in all notices sent in any U.S. county if 10% or more of the county's population is literate only in the same non-English language.

Miscellaneous

The Final Regulations provide that plans must inform claimants of any contractual limitations period and its expiration date in a notice of adverse benefit determination. Also, the Final Regulations clarify that extended timeframes for deciding disability claims, provided by the quarterly meeting rule, apply only to multiemployer plans.

Effective Date

The Final Regulations are effective January 18, 2017, and will apply to claims for disability benefits filed on or after January 1, 2018.

Next Steps

Generally, the Final Regulations mirror the requirements set forth in the ACA Final Rule, with limited exceptions. It appears that the DOL intends to streamline claims and appeals processes so that plans will not have to implement significantly different systems for disability benefits claims and other claims. Therefore, non-grandfathered health and welfare plans will likely be able to model disability benefit claims procedures based on existing group health plan benefit claims procedures with little difficulty.

However, the Final Regulations may significantly impact pension plans and grandfathered health and welfare plans that provide disability benefits. Unlike non-grandfathered health and welfare plans, which are already subject to the ACA

Final Rule, pension plans and grandfathered health and welfare plans that provide disability benefits may not have claims and appeals procedures that comply with the proposed regulations.

Any ERISA-covered pension or health and welfare plan that provides disability benefits should review its claims and appeals procedures for compliance with the Final Regulations. Most plans will likely need to update their procedures to comply with the new timeline and disclosure requirements under the Final Regulations.

Affected plans should ensure that proper procedures are in place to provide claimants with new responses and rationales for adverse benefit determinations. In particular, pension plans and grandfathered health and welfare plans that provide disability benefits should review claims and appeals notices for disability benefits to ensure that content requirements under the Final Regulations are met.

[1] Generally, the final regulations apply to all employee benefits plans subject to ERISA that provide disability benefits. However, if a plan provides a benefit conditioned on a finding of disability made by a third party (*e.g.*, the Social Security Administration), such claim for benefits is not treated as a disability claim subject to the final regulations.