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Department of Labor Proposes Update to Disability Benefit Claims Regulations

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On November 18, 2015, the Department of Labor ("DOL") published proposed regulations to update plans' internal claims and appeals procedures for determining disability benefit claims. The proposal is meant to bring in line the adjudication of disability benefit claims with claims and appeals procedures for non-grandfathered group health plans under the Affordable Care Act ("ACA"). The update reflects the first refresh since the current regulations governing the processing of claims and appeals were published 15 years ago. The DOL has asked for public comments on the proposal within the next 60 day period.

The proposal largely adopts, with some modification, the procedural protections afforded to health claims under the ACA. The November 18 publication of the proposed disability claims regulations in the Federal Register coincided with the same-day publication of final regulations on the internal claims and appeals processes for non-grandfathered group health plans under the ACA, which finally adopted the interim final regulations and amendments that were issued in 2010 and 2011.

The DOL's proposal seeks modification of the existing claims and appeals procedures for disability claims in the following areas:

1. Explicitly requiring plans 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." Under the proposal, decisions regarding hiring, compensation, termination, promotion, or similar matters regarding the claims adjudicator or medical expert must not be made based on the likelihood that the individual will support the denial of benefits.

2. Requiring that benefit denial notices fully discuss the reasons for the denial and the internal rules, guidelines, protocols, and standards on which the denial is based. Adverse benefit determinations for disability benefit claim would have to include the basis for the decision's disagreement with any disability determination by the Social Security Administration, a treating medical provider, or other source of disability benefits, if the plan did not agree with those determinations. The notice of an adverse benefit determination would also need to state that the claimant is entitled to receive, upon request, relevant documents (a right previously only required to be afforded on denials of benefit appeals).

3. Explicitly providing that claimants have the right to review and respond to new evidence or a new rationale for a denial in advance of the appeal decision, and facilitating

claimants' access to their entire claim file and claimants' ability to present written evidence and testimony to the decision makers.

4. Strengthening required adherence by plans to the claims processing rules by allowing a claimant to bring his or her disability benefits claim to court without completing the plan's internal claims and appeals process (effectuating deemed exhaustion of the administrative remedies under the plan) where a plan deviates from the mandated claims process, except only under limited circumstances. Where deemed exhaustion occurs, the proposal provides that the reviewing court should review the plan's decision *de novo*, without any deference. Also, if the court rejects a claimant's attempt to seek judicial review under deemed exhaustion, the proposal provides that the claim would be considered as re-filed on appeal upon the plan's receipt of the court's decision, thereby providing the claimant with an opportunity to present evidence and testimony to the appeals decision maker.

5. Treating certain rescissions of coverage *(i.e.*, cancellations or discontinuance of disability coverage retroactively regardless of whether there is an resulting adverse effect on any particular benefit) as adverse benefit determinations, which thereby allows a claimant to submit an appeal through the plan's internal appeals process. Unlike the definition of rescission in the final rules for non-grandfathered group health plans under the ACA, the proposed definition of rescission for the disability claims would not be limited to cancellations of coverage occurring as a result of fraud or intentional misrepresentation of material fact.

6. Requiring notices to be written in a culturally and linguistically appropriate manner, as defined under the regulations, similar to that required for non-grandfathered group health plans under the final rules under the ACA. If the claimant's address is in a county where ten percent or more of the population, as determined by U.S. Census Bureau data, is literate only in the same non-English language, notices of benefit determinations need to include a statement in the applicable non-English language about the ability to access a telephone number for assistance in that non-English language and the ability |to request written notices in the non-English language upon request. The languages relevant to this proposed rule are currently Spanish, Chinese, Tagalog, and Navajo.

7. Clarifying, via a technical correction, that the quarterly meeting rule in the current claims regulations (which extend the time for deciding disability claims for decision makers that meet only on a quarterly basis) is applicable only for multiemployer plans.

While soliciting comments in general on the proposal, the DOL has also expressly requested comments on two specific topics. First, it seeks comments regarding whether it should modify the existing timing rules for deciding disability benefit claims to allow claimants and plans sufficient time to engage in a dialogue regarding new evidence and rationales prior to the determination of the claim or appeal. The proposed disability regulations did not adopt the tolling provision from the final rule for non-grandfathered health plans under the ACA, but the DOL appears open to considering some kind of modification to the existing timing rules under the current disability claims regulations. Second, the DOL seeks comments on whether the regulations should require plans to provide, in the final notice of adverse benefit determination on appeal, a statement of

the plan's applicable contractual limitations period and the period's expiration date. The DOL suggested that perhaps there should be a required disclosure, in light of the Supreme Court's decision in *Heimeshoff v. Hartford Life & Accident Ins. Co.* that upheld the use of contractual limitations periods in plans as long as the periods were reasonable and in light of the disagreement among courts regarding whether plans must provide notice of such contractual limitations periods in their adverse benefit determinations. See our article about a recent court decision on this issue in the September *Benefits Report*.

The DOL's proposal regarding disability claims was not surprising in light of the existing connection between disability claims and health claims requirements under the 2000 DOL claims regulations (the existing claims regulations applicable to disability claims) and in light of the new required procedures for health plan claims under the ACA. It is likely that the proposal will be adopted by the DOL in substantially (albeit, not exactly) the same form, because of the proposal's firm grounding in the final regulations regarding adjudication of group health plan claims. Stay tuned for a future update.

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