TRUCKER ✦ HUSS

DOL Finalizes Disability Benefit Plan Claims Regulations

TIFFANY N. SANTOS

On December 19, 2016, the Department of Labor finalized the regulations governing disability benefit claims (see https://www.gpo.gov/fdsys/pkg/FR-2016-12-19/pdf/2016-30070.pdf). Intended "to promote fairness and accuracy in the claims review process and protect participants and beneficiaries in ERISA-covered disability plans," the regulations for the most part adopt the rules proposed in November 2015 that align the adjudication of disability benefit claims with the claims and appeals procedures that govern non-grandfathered health plans under the Affordable Care Act (see our article on the proposed disability benefit claims regulations).

As the regulations apply to all claims for disability benefits filed on or after January 1, 2018, plan sponsors and administrators should familiarize themselves with the new requirements and timely amend plan documents, summary plan descriptions, and related procedures accordingly.

The finalized regulations require:

- **Independence and Impartiality in Decision-making:** Plans must determine claims and appeals "in a manner designed to ensure independence and impartiality of the persons involved in making the benefit determination":
  - The regulations prohibit plans from "making decisions regarding hiring, compensation, termination, promotion, or other matters with respect to any individual (such as a claims adjudicator or medical or vocational expert)" based on the likelihood that the individual will support the denial of benefits *(note: the final regulations add vocational experts).*
- **Improved Disclosure:** To help ensure reasoned explanations of a denial, the regulations require all notices of adverse benefit determination (claim or appeal level), to discuss and explain the basis for disagreeing with or not following:
  - The views presented by the health care professionals who treated the claimant and the vocational professionals who evaluated the claimant;
  - The views of medical and vocational experts whose advice was obtained on behalf of the plan without regard to whether the advice was relied upon in making the benefit determination;

- The claimant's disability determination by the Social Security Administration ("SSA"), if presented by the claimant.

Similar to the requirements applicable to adverse benefit determinations under non-grandfathered health plans, the regulations require disability benefit plans to include the following in adverse benefit determinations at the initial claim and appeal levels:

- An explanation of the scientific or clinical judgment for any adverse benefit determination that is based on a medical necessity or experimental treatment or similar exclusion or limit, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;
- Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan that were relied upon in making the adverse benefit determination, or a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist; and
- 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 claim for benefits *(note: the regulations currently in effect do not require this statement in initial claim denial notices)*.

- **Rights to Review and Respond to New Information or New Rationale Before Final Decision:**
  - New Information: If a disability benefit plan, insurer or other person making the benefit determination considers, relies upon or generates new or additional evidence in connection with the review of a denied claim, the plan must provide the claimant, free of charge, with such new evidence as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination is required to be provided to give the claimant a reasonable opportunity to respond prior to that date;
  - New or Different Rationale: If a disability benefit plan intends to issue an adverse benefit determination at the appeal level that is based on a new or additional rationale, the plan must provide the claimant, free of charge, with the rationale as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination is required to give the claimant a reasonable opportunity to respond prior to that date.
- **Disclosure of Any Contractual Limitations Period in Denial Notices:** Existing claims regulations require denial notices to include a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review. To ensure that this statement is complete and not misleading, the regulations now require such denial notices to include a description of any applicable contractual limitations period and its expiration period, if any (for example, 1-year limitations period measured from the date of the adverse benefit determination on appeal that expires on January 4, 2018).
- **Deemed Exhaustion of Claims and Appeals Processes:** Tracking the regulations applicable to non-grandfathered health plans, the final rules allow a claimant to file a civil suit under Section 502(a) immediately without exhausting the plan's administrative

remedies if the plan fails to comply with the claims review regulations, unless the violation is (i) *de minimis*; (ii) non-prejudicial; (iii) attributable to good cause or matters beyond the plan's control; (iv) in the context of an ongoing good faith exchange of information; and (v) not reflective of a pattern or practice of non-compliance. The regulations further require a plan to provide a written explanation of the violation within 10 days upon a claimant's request, including a specific description of its bases, if any, for asserting that the violation should not cause the administrative remedies available under the plan to be deemed exhausted *(note: in the preamble to the final regulations, a footnote clarifies that the new regulation supersedes all prior conflicting DOL guidance with respect to disability benefit claims, including but not limited to the deemed exhaustion discussion in Frequently Asked Question F-2, (see https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/benefit-claims-procedure-regulation)*.

- **Retroactive Rescissions of Coverage Are Appealable:** The regulations require a rescission of coverage that has a retroactive effect to be treated as an adverse benefit determination that triggers the claimant's right to file an appeal, except if the cancellation or discontinuance of coverage stems from a failure to timely pay required premiums or contributions towards the cost of coverage.

- **"Culturally and Linguistically Appropriate" Notices:** Adopting the standards applicable to non-grandfathered health plans under the Affordable Care Act, the regulations require plans to provide notices in a "culturally and linguistically appropriate manner." This means that if a claimant's address is in a county where 10% or more of the population is literate only in the same non-English language as determined by guidance published by the United States Census Bureau (currently these are Chinese, Tagalog, Navajo and Spanish), any denial notice to the claimant must prominently disclose how to access the plan's language services in that non-English language. The plan must also provide a customer assistance process (such as a telephone hotline) with oral language services in the applicable non-English language (such as assistance with filing claims and appeals) and provide written notices translated in that non-English language upon request.

If you have any questions regarding the foregoing, please contact the author of this article.

DECEMBER 2016

EMAIL TIFFANY SANTOS