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DOL Says New Disability Claim Regulations to Apply April 1

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The U.S. Department of Labor (DOL) recently announced that the revised Employee Retirement Income Security Act of 1974 (ERISA) disability benefit claim regulations will apply to claims filed on and after April 1, 2018. The amendments were originally slated to be applicable to disability benefit claims filed on or after January 1, 2018, but, in December of 2017, the department delayed the applicability date to April 1, 2018. There will be no further delays.

In November of 2015, the department proposed substantial amendments to the claim regulations applicable to ERISA disability benefit claims. It offered three reasons for revising the disability benefit claim procedures: (1) the department wished to bring the disability regulations in line with earlier changes to the healthcare claim regulations necessitated by the Affordable Care Act; (2) the department sought to counter perceived increases in disability benefit claim litigation; and (3) the department contended that the revised regulations would reduce the cost and perceived delays in processing disability benefit claims.

The proposed regulations were finalized in December 2016. The 2016 amendments do not eliminate any of the requirements applicable under the current regulations that have been applicable since 2002. Instead, the 2016 amendments add new and different requirements that will supplement the amount of work involved in processing a disability benefit claim, will likely cause additional delays in making disability benefit claim decisions, and will increase the cost of processing disability claims and the amount of litigation that arises from such claims. This article will summarize some of the more significant changes and their likely impact on claimants and disability plans.

Right to Review New Evidence and Rationales

The current rules do not require an ERISA plan to disclose evidence received or generated during the appeal phase until after a final decision is rendered. Efforts by plaintiffs to convince courts to add such a requirement and to also require plans to give claimants a chance to respond to the new evidence before the plan renders its decision have been largely for naught. This is primarily due to courts' conclusion that no such requirement existed in the 2002 regulations and their concern that such a requirement would result in an endless back-and-forth between the plan and the claimant, delaying the decision process as well as increasing the cost of the appeal process.

The 2016 amendments add a new requirement applicable during the claim appeal phase: a plan

must give a claimant reasonable time to review and respond to “new or additional evidence” or a “new or additional rationale” for denying his or her claim. This requirement in and of itself is probably not an issue to the extent it is intended to reflect what is already a common practice by many disability plans. Note that it is not unusual for plans to provide a copy of an independent medical examination report or other significant medical review to the claimant and/or the claimant’s treating physician for comment before rendering a final appeal decision. Many carriers also require consulting physicians to contact treating providers to discuss their different views of the medical record before an appeal determination is issued.

What makes the amendment problematic is that the department places no limits on the amount of back-and-forth required. Nor is there any adjustment in the time allowed for rendering a decision in order to accommodate this additional procedure. One would hope that the review and respond process would happen only once during the appeal phase (i.e., all new evidence would be forwarded to the claimant and the claimant would be given adequate time to respond to all of the evidence at one time). Discussion in the preamble to the final regulations seems to anticipate this possibility. However, the preamble also suggests that when the claimant does respond, if the response prompts further review by a medical professional, which is likely (and may be required by the regulations), the plan may need to send the matter to the claimant for another response, and so on.

Part of the problem is the regulations’ failure to define what constitutes “new or additional evidence” or a “new or additional rationale”—despite pleas by various commenters requesting such clarification when the proposed regulations were issued. New evidence might mean new facts, or it might mean a new medical opinion based on the same facts. Is an additional medical review “new or additional evidence”? The DOL declined to expand on these concepts, leaving it to the parties and the courts to sort it out in litigation.

As for timing, it is unlikely this added requirement could be accomplished under the current time frames without significant tolling of the decision deadline. For example, when a disability plan gives a claimant a “reasonable time” (also not defined by the DOL) to respond to “new or additional evidence” or a “new rationale,” the time for deciding the claim must be tolled or the process will simply break down. The DOL acknowledged concerns expressed on this point but did not incorporate them in its rush to get the regulations finalized before the end of the Obama administration. Again, only time and litigation will resolve the issue.

“Deemed Exhausted” Requirement

One of the more troublesome new requirements is that a plan must “strictly adhere” to the claim procedures. This rule is intended to overturn decades of case law, which determined that only “substantial compliance” with the regulations is required. The “strictly adhere” requirement is combined with a rule that allows claimants to unilaterally terminate the claim process at any time for any perceived error. Claimants have the option to provide advance notice to the plan of their belief that the plan has not complied with the regulations, but they are not required to do so. Claimants can go directly to court to determine whether an error occurred and whether the alleged error was “de minimis.” This is a term of art under the amended regulations that takes into account a host of factors, including lack of prejudice to the claimant, good faith, whether the parties are engaging in ongoing communication, whether the error is part of a pattern and practice, and so on.

Issues With the Deemed Exhausted Requirement

One problem with this requirement is that it is likely to establish a veritable cottage industry of claim

procedure litigation. There is no limit on the number of times a claimant can terminate the claim process based on perceived procedural violations, nor are there any apparent restrictions on what a claimant determines are the proper bases for alleging a claim violation. There is also no penalty to a claimant for filing a groundless lawsuit. To the contrary, if the claimant is wrong, the claimant is merely allowed to return to the claim process as if nothing happened.

The possibilities for gamesmanship are obvious. Claimants' attorneys who want to force a settlement may launch premature litigation on the pretext of a claim violation in order to force the plan to incur litigation costs and thereby incentivize it to settle a disputed—and potentially doubtful—claim. At the very least, claimants' attorneys may threaten to do so. Even where there is a legitimate procedural issue, it still makes little sense to truncate the claim process. What if the plan were to ultimately approve the claim? By forcing the claim into litigation before there is a claim determination, the claimant may suffer months or years of delay in receiving benefits.

Finally, the DOL opines that where a plan does not strictly comply with the claim regulations, a court should not apply deferential review. However, this is not the department's decision; the decision on what judicial review standard to apply rests solely with the courts. The department's position also ignores binding case law from the Supreme Court of the United States, which determined that an honest mistake does not deprive a plan fiduciary of plan-granted discretionary authority.

A Proposal on the Deemed Exhausted Regulations

For these and other reasons, the DOL should have jettisoned this "deemed exhausted" provision. At a minimum, the regulations should have required advance notice and an opportunity for plans to respond and correct the process. That would not necessarily prevent unscrupulous lawsuits, but at least it would help avoid misunderstandings that can lead to delays and avoidable costs. Finally, where a claimant does pursue a frivolous suit, there ought to be a penalty of some kind, including forfeiting the right to further pursue the claim. The department acknowledged all of these concerns and rejected them.

Disclosure Requirements

The proposed claim amendments also required a plan that is denying a claim to affirmatively respond to contrary recommendations or decisions by treating doctors and other third-party payers, including the Social Security Administration (SSA). It is already common practice for disability plans to discuss treating physician opinions and to distinguish contrary SSA decisions, so the proposal did not add anything new on that front. The requirement to discuss the opinions of other third-party payers, however, would greatly increase costs. For example, if another disability or pension plan makes a disability benefit determination, the plan would be required to determine the criteria for that decision, to determine the bases for the third-party decision, and to obtain the record evidence in the possession of the third-party payer in order to evaluate the decision. Not only that, but unlike SSA files, which are fairly static once a decision is rendered, private disability plans typically require ongoing review, which means that the files are dynamic and constantly changing, requiring a plan to constantly request updates from the third-party payer.

In finalizing the regulations, the DOL admitted that a requirement to respond to decisions by third-party payers was unworkable and limited the requirement to responding to opinions of claimants and their doctors and vocational experts as well as SSA decisions. The DOL expressly rejected incorporation of a treating physician rule as was suggested by many in the plaintiffs' bar. At the end of the day, the final requirement essentially memorializes current practice by most disability claim

administrators.

The amendments require that a notice of an adverse benefit determination include disclosure of any rules or guidelines used in denying the claim or a statement that such rules or guidelines do not exist. This is primarily an attempt to bring disability claim regulations in line with the medical claim regulations. The primary problem with this requirement is that there are fundamental differences between medical claims and disability claims. Medical plans typically have detailed guidelines to decide issues related to medical necessity or whether treatment is experimental. In contrast, disability benefit plans rarely have such specific guidelines because disability benefit claims are highly fact-specific and rarely follow the common patterns seen in medical claims. Typically, disability benefit plan language is the primary guideline for claim administrators, and plans are already required to include applicable policy language in their denial letters. It is one thing to require disclosure where there is a guideline actually used in denying a claim, but it is quite another thing to require disability plans to guess whether some term in a company's claim manual might possibly be construed as being applicable so that the plan can accurately attest that no such guideline exists.

The clearest evidence of this problem is the requirement that where an adverse benefit determination is rendered in a disability benefit claim and is based on a "medical necessity or experimental treatment or similar exclusion," there must be an explanation of the scientific or clinical judgment for the determination. Medical necessity and experimental treatment are rarely, if ever, applied in the context of disability benefit claims. Even if one could fathom how they might apply in the disability benefit claim context, other portions of the regulations requiring a plan to explain why it reached an adverse benefit determination are more than sufficient to satisfy the requirement that a plan must explain the bases for its decision.

Independence and Impartiality

According to the DOL, disability benefit plans must ensure that hiring and other employment decisions related to claims adjudicators or medical or vocational experts are not based on the likelihood that the person will support a denial of benefits. This requirement seems innocuous and reflects longstanding industry practice. What is more problematic is that the preamble continues the DOL's proposal that outside experts cannot be hired "based on the expert's reputation for outcomes in contested cases, rather than based on the expert's professional qualification."

This requirement on outside experts raises a plethora of questions. For example, how does one define what an expert's "reputation" entails? Would his or her reputation be analyzed from the claimant's perspective or the disability benefit plan's perspective? The DOL also fails to address how this information will be disclosed or whether it will lead to unnecessary discovery. Will discovery require production of an expert's opinions regarding other claimants to determine the expert's "reputation"? Would such discovery be limited to claimants under the same plan, or would it extend to other plans and programs? And what does the department mean by "reputation for outcomes in contested cases"? Once again, this is likely to lead to more litigation.

Notices for Contractual Limitations Periods

The amendments now mandate that disability plans are required to disclose contractual limitations periods in denial letters. Plans are also required to compute and disclose the actual calendar date on which the contractual limitation period expires.

The circuits are currently split on whether contractual limitations periods need to be disclosed.

Disclosure of a plan’s limitations language, if any, is probably not too burdensome. However, asking disability benefit claim personnel to essentially practice law by evaluating, interpreting, and calculating lawsuit deadlines may be unduly burdensome. It does appear that the requirement does not apply to statutory limitations periods and only applies to contractual limitations periods.

One reason for this requirement might be that because ERISA does not contain a limitations period for benefit claims, courts default to the most analogous state statutory period. Thus, the applicable statutory period can vary from jurisdiction to jurisdiction. When a benefit claim is denied, a plan will not know if or where it will get sued and therefore cannot predict what statutory period may apply. Query, then, whether the requirement to disclose a contractual period would or should apply where the contractual period is merely a statement of a period mandated by state insurance statutes, which is most often the situation where the disability plan is insured.

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