ERISA Disability Claim Regulations Get a Facelift

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Employers providing disability benefits to their employees should note that the U.S. Department of Labor recently changed how disability benefit claims are administered. The new disability claim rule will apply to ERISA-governed disability benefits claims—i.e., claims under private sector employee benefit plans—that are filed on or after January 1, 2018. The new rule is designed to increase fairness and transparency, and hopefully cut down on the number of disability lawsuits that get filed, though it remains to be seen whether the rule will have the intended effect. Employers will want to make sure their claim administrators and providers are familiar with the new rule and ensure that their benefit plans and claim processes comply. Here's a quick overview:

Impartiality

Plans must ensure independence and impartiality of persons involved in claims determinations, and accordingly, ". . .decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any 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." According to the U.S. Department of Labor (DOL) overview, if a plan consults with a medical expert, it should consider his or her professional qualifications, not any reputation for claim outcomes. If a plan sets up an independent review through an outside vendor, the plan should take steps to ensure that the vendor is compliant. (The DOL suggests that plans could incorporate terms in their service contracts and engage in "ongoing monitoring.") Claim analysts cannot be compensated based on whether or how often they may deny claims.

While this restates what ERISA plans already know—do not incentivize claim denials—practitioners, employers, and administrators should expect that plaintiffs will use the rule in litigation to engage in broad-reaching "conflict" discovery. The DOL has acknowledged this concern and stated that the rule does not change the scope of the "relevant documents" required for disclosure under ERISA, but it also conceded that the rule does not prescribe the appropriate scope of discovery in litigation.

Thus, while the rule is intended to reduce conflict and claim disputes, it probably does little to change how plans already operate on this front. At the same time, it threatens to increase discovery and litigation costs, contrary to ERISA's goals. Conkright v. Frommert, 559 U.S. 506, 517 (2010) ("Congress sought '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.'" (quoting Varity Corp. v, Howe, 516 U.S. 489, 497 (1996)).

Review and Response

When reviewing claim appeals, administrators often gather new information such as medical reviews or vocational assessments to help analyze a claim. With the rule, administrators now will be required to share any such new evidence—and any new claim rationales—with an employee before making a decision, giving the employee a "reasonable opportunity" to respond. The rule states that the information should be provided "as soon as possible," but the DOL clarified this to mean as soon as the administrator realizes the information is going to result in denial. The DOL dismissed concerns that this new procedure would require an "endless loop" between the employee and administrator, reasoning that the claimant's "submissions ordinarily become repetitive in short order," and administrators should not feel compelled to "endlessly rebut credible evidence. . ." Building in time for employee reaction will make it challenging for appeal analysts to meet ERISA's 45-day decision deadline, but the DOL notes that ERISA's "special circumstances" provision may be used to extend and toll the deadline.

Additional Disclosures

The DOL reinforced and enhanced the disclosures required for adverse benefit determinations, (which, by the rule, now expressly include decisions to rescind or cancel):

- A discussion regarding why the administrator agrees or disagrees with (1) the claimant's treating providers; (2) any other medical or vocational expert opinions that were obtained (regardless whether their opinions were relied on); and (3) any disability determinations made by Social Security or third parties.
- The specific internal rules, guidelines, protocols, standards, or criteria relied upon or an affirmative statement that no such criteria exist.
- Initial benefit denials, similar to appeal decisions, now must notify participants of their right to receive relevant documents.
- Benefit correspondence must be "linguistically and culturally appropriate" to accommodate non-English claimants.
- Any contractual limitations periods must be reasonable and noted in appeal decisions.

Non-Compliance

If a plan does not "strictly adhere to all" of ERISA's claim procedure requirements, a claimant may fast-forward to litigation and the claim is "deemed denied on review without the exercise of discretion by an appropriate fiduciary." This rule will likely result in more litigation; plaintiffs may rush to court without having fully exhausted the available administrative remedies, causing judges to more often become "substitute plan administrators," contrary to congressional intent. See, e.g., Roganti v. Metro. Life Ins. Co., 786 F.3d 201, 217 (2d Cir. 2015) (noting that Congress never "intended that federal district courts would function as substitute plan administrators") (internal quotations omitted). While the DOL noted that the rule might result in de novo review in court, the rule does not expressly prescribe the standard for judicial review. Also, notably, the rule still makes exception for minimal violations that are non-prejudicial, with good cause, in the context of an ongoing dialogue and not reflective of a pattern and practice of non-compliance.

Scope

While the regulations clearly apply to disability benefit plans, employers should examine compliance for all employee welfare benefit plans (such as retirement, health, or life), any of which may condition benefit eligibility on a disability determination.

The DOL's expressed desire to reduce the number of disability disputes is laudable. It remains to be seen, however, whether the new regulations will advance that goal, and if so, whether any advance is worth the increased regulatory burden and likely increased litigation costs borne by administrators and plans. Regardless of the effects, this recent makeover necessitates a thorough review by employers and their ERISA administrators to ensure compliant claim and appeal procedures, plan documents, benefit communications. and service contracts.

If you have any questions regarding this alert, please contact your Lathrop Gage attorney or the attorney listed above.