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The new ERISA disability claims regulations that went into effect in April offer people more procedural protections when their benefits are denied. Here's what you need to know.

The new Employee Retirement Income Security Act (ERISA) disability claims regulations are not a dramatic change from the status quo, but they mark progress toward greater fairness in claims adjudication that first began when the regulations were revised nearly 20 years ago. They will impact the practices of attorneys who regularly represent disability benefit claimants, and they also will help general practitioners who may not regularly handle ERISA claims avoid unanticipated procedural snares.

ERISA was passed to protect employee pensions and other retirement benefits. But shortly before the law was enacted in 1974, Congress dramatically expanded ERISA's scope to encompass "welfare" benefits—primarily health, life, and disability benefits. Most ERISA litigation relates to welfare benefit disputes, but before a claimant may file a lawsuit, federal courts have required them to exhaust pre-litigation appeals—consistent with the congressional directive that claimants whose benefits are denied should receive a "full and fair review."[1]

The U.S. Department of Labor (DOL) developed regulations governing the benefit claims and appeals process. Despite updates in 2000[2] that clarified the process even more, claimants, who make up nearly two-thirds of plaintiffs in ERISA lawsuits,[3] were often denied full and fair claim reviews.

In 2015, the DOL issued a notice of proposed rulemaking specifically relating to disability benefit claims.[4] After receiving nearly 150 comments on the proposed rules—some from the insurance industry, which argued that the new regulations would increase premiums and the cost of claims processing—the department issued a final set of regulations without alterations in late 2016.[5] They became effective April 1, 2018.[6] Because the new regulations have made the claims process more transparent and accessible, attorneys have more tools at their disposal to advocate for claimants with meritorious claims.

The New Rules

In the preamble to the notice of proposed rulemaking issued in 2015, the DOL explained that the new rules are based on the following goals:

- Potential conflicts of interest by people involved in adjudicating claims must be mitigated to promote impartiality and fairness in the process.
- Denial notices must offer more thorough explanations about the basis for and the standards used in rendering claim decisions. They must also articulate reasons for disagreement with evidence supporting the claimants, such as treating doctor opinions, vocational reports, and favorable Social Security determinations.
- Claimants must be given timely and enhanced notification of their right

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to receive their entire claim file and other relevant evidence.[7] Claimants also must be given expanded rights to present evidence and testimony supporting their claims during pre-litigation review.

- Claimants must be given notice and an opportunity to respond to any new adverse evidence or rationales developed during the claim appeal—for example, in situations when the plan administrator may advance a new reason for denying benefits that was not articulated in the initial denial.
- Benefit plans may not assert the claimant's failure to exhaust administrative remedies in court if the plan has failed to comply with the claim procedure requirements.
- Claimants must be given notification of when the relevant limitations period to file suit would expire.[8]

Conflicts of interest. The new regulations provide that "decisions regarding hiring, compensation, termination, promotion, or similar matters with respect to any individual must not be made based upon the likelihood that the individual will support the denial of disability benefits."[9]

To promote this goal, the regulations articulate new conflict-of-interest rules[10] derived from court rulings[11] that have expressed concern about bias in claims handling. For example, benefit plans cannot offer bonuses to adjudicators who increase their rates of benefit denials.

The regulations also prohibit claim adjudicators from selecting medical and vocational experts based on their track record or tendency for denying claims—a significant change, since insurers typically rely on the same limited pool of physicians to review the medical files associated with disability benefit claims. Any third-party vendors that benefit plans use to select consultants also must implement practices to avoid conflicts of interest. Attorneys handling disability insurance claims can use these new rules to raise allegations of bias if research on particular consultants reveals a pattern of denials or if discovery in previously litigated cases reveals such conflict issues.

Denial letters and disclosure requirements. A key addition provided by the new regulations is that benefit plan denial letters must now articulate the basis for disagreeing with the views and opinions of the claimants' treating health care providers and vocational experts.[12] As a matter of "fiduciary accountability," benefit plans also must disclose all opinions obtained from consultants, regardless of whether they relied on those opinions. This precludes concealment of opinions from consultants who may have favored the payment of benefits.

Prior to this, plan administrators could simply offer conclusory statements of disagreement with the treating doctors, but this new rule may be used to challenge

a denial when the claimant's attorney can point out the absence of a reasoned explanation behind a consultant's differing opinion.

Consideration of Social Security disability determinations. The regulations do not require benefit plans and insurers to follow Social Security disability benefit determinations, but they must provide more substantive rationales if their conclusions differ from those made by the Social Security Administration (SSA). Given the stringent definition of "disability" contained in the Social Security Act, which imposes on the claimant a burden to establish an inability to perform any "gainful" work,[13] the regulation provides that "a more detailed justification would be required in a case where the SSA definitions were functionally equivalent to those under the plan."[14] The regulation makes it clear that such justifications require more than merely asserting differences between the Social Security Disability Insurance program and ERISA-governed disability benefits.

Based on this new regulation, attorneys handling ERISA cases should try to obtain the complete Social Security claim record from the SSA, which will reinforce the persuasiveness of the Social Security determination and also preclude insurers from disregarding it on the ground that there is no basis for understanding the rationale behind the Social Security award.

Disclosure of insurer protocols. All insurance companies and benefit plans maintain policies, rules, and guidelines that they rely on in adjudicating claims. Although many insurers deem such materials proprietary or confidential, the DOL now mandates disclosure of these documents, including "internal rules, guidelines, protocols, standards or other similar criteria of the plan" that are relied on when "making the adverse determination."[15] This enhances claimants' ability to challenge denials that are based on questionable sources—for example, those that purport to determine the expected duration of a disability or that may classify certain conditions as behavioral to limit the duration of benefit payments. When plaintiff attorneys have the opportunity to see the documentation that the insurer relied on, they can consult other, more authoritative medical texts and journals that might rebut the insurers' information.

The claim appeal may constitute the last opportunity to create and shape a 'record' for future litigation if the appeal is unsuccessful.

Challenge adverse evidence. One of the biggest problems with obtaining ERISA disability benefits is when claimants are "sandbagged" with newly developed evidence gathered by insurers and benefit plans during the claim appeal process. Because most courts analogize ERISA claim litigation to administrative review,[16] claimants cannot challenge adverse evidence in court—trials with cross-examinations and even depositions of adverse witnesses generally are not allowed.

A new rule, however, expands claimants' rights to challenge adverse evidence: They must be provided and be given the opportunity to respond to adverse information that first comes to light only after the claimant's appeal of a benefit denial.[17] The DOL explained that "claimants are deprived of a full and fair review, as required by [S]ection 503 of ERISA, when they are prevented from responding, at the administrative stage level, to all evidence and rationales."[18]

Although the new rule may delay claim processing, the DOL maintained that the need for fairness and accuracy was more important than expediency, noting that restrictions on discovery and evidence that courts have placed on ERISA claimants in benefit disputes made the rule necessary.

The DOL also made it clear that the claims process is intended to be informal and that submissions from claimants are not required to meet "courtroom evidentiary standards."[19] Thus, claimants may include audio, video, and other electronic media, as well as statements from lay witnesses as part of their submission. This is especially useful in the face of insurers' growing reliance on claimants' social media postings. The new regulation gives claimants a better opportunity to rebut adverse inferences that insurers may draw from misleading Facebook, LinkedIn, Instagram, or other social media postings.

Be prepared to take advantage of this new rule by presenting a timely rebuttal to adverse evidence. Since the rules of evidence are inapplicable, claimants can and should submit rebuttals to insurers that rely on social media by explaining why the information is inaccurate or has been mischaracterized.

Clarified time limitations for filing suit. When the DOL issued its initial notice of proposed rulemaking, it asked for suggestions about including

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provisions that clarified the time limitations for filing suit. Many benefit plans contain contractual limitations periods that are shorter than otherwise applicable state statutes of limitations. The U.S. Supreme Court, in *Heimeshoff v. Hartford Life & Accident Insurance Co.*, ruled that courts will enforce those contractual limitations periods in ERISA-governed benefit plans.[20]

Fortunately, the new regulations include a provision that tolls limitations periods during presuit claim appeals and mandates that denial notices specify the applicable limitations period and when the insurer or plan administrator believes it would expire.[21]

The biggest change in the revised regulations is the claimant's expanded opportunity to review and comment on adverse evidence.

This new rule obviates *Heimeshoff*, which found that a disability benefit claim was time-barred even though it was unclear whether the limitations period accrued when the claim first arose, when benefits were terminated after having been paid for a period of time, or when the pre-litigation claim appeal was exhausted.[22] The new rule removes the confusion by creating a safe harbor in which claimants can file suit prior to the date set forth in the denial letter without fear of the action being time-barred.

Exhaust administrative remedies. The new regulations also cleared up issues related to the existing regulations' "deemed exhaustion" requirements. ERISA benefit claimants must exhaust all pre-litigation appeals as a condition of bringing suit, and the regulations now clarify that any violation of the ERISA claim regulations by the plan will meet the deemed exhaustion requirements, permitting the claimant to immediately file suit unless the violation is de minimis, nonprejudicial, or not attributable to the plan's conduct.[23]

Further, when a deemed exhaustion occurs—such as when the plan fails to issue a timely decision—the standard of judicial review would be de novo rather than the often arbitrary and capricious standard of review that gives deference to the claim administrator's determination. The regulations also contain a requirement—mirroring a provision incorporated into Affordable Care Act regulations—that decisions must be written in a culturally and linguistically appropriate manner.[24]

What was left out. Many commentators who represent or advocate for ERISA benefit claimants sought a rule that would mandate deference to treating doctor opinions in reaction to *Black & Decker Disability Plan v. Nord*.[25] In that case, the Supreme Court found no basis for according deference to a treating physician opinion in the absence of a regulation from the DOL. However, the agency did not adopt such a rule. It also rejected issuance of a rule specifying the standard of judicial review applicable in court proceedings relating to employee benefit claim disputes.[26]

What Lies Ahead

The biggest change in the revised regulations is the claimant's expanded opportunity to review and comment on adverse evidence. Most insurers already have anticipated this and implemented procedures allowing for review and comment, giving claimants a fairer opportunity to establish entitlement to benefits.

Become familiar with the new regulations, and be ready to use them. Keep in mind that your work may not be complete once the claim appeal is submitted—you will need to be ready to quickly rebut adverse evidence or the advancement of new grounds for a claim denial. The claim appeal may constitute the last opportunity to create and shape a "record" for future litigation if the appeal is unsuccessful. Although thorough appeals are more likely to be approved, not every appeal is successful—always contemplate the possibility of future litigation.

The guiding principles expressed by the regulations further the intent behind ERISA's passage: to protect the interests of employees and their beneficiaries—and to make sure that promises made are promises kept. The regulations go a long way in achieving those goals. T

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Notes

1. 29 U.S.C. §1133(2) (2017).
2. Employee Retirement Income Security Act of 1974; Rules and Regulations for Administration and Enforcement; Claims Procedure, 65 Fed. Reg. 70245 (Nov. 21, 2000).
3. Claims Procedure for Plans Providing Disability Benefits, 81 Fed. Reg. 92316 (Dec. 19, 2016) (citing Sean M. Anderson, *ERISA Benefits Litigation: An Empirical Picture*, 28 ABA J. Lab. & Emp. L. 1, 1 (2012)).
4. Claims Procedure for Plans Providing Disability Benefits, 80 Fed. Reg. 72014 (Nov. 18, 2015).

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5. Claims Procedure for Plans Providing Disability Benefits, 81 Fed. Reg. at 92316.
6. Claims Procedure for Plans Providing Disability Benefits; 90-Day Delay of Applicability Date, 82 Fed. Reg. 56560 (Nov. 29, 2017). The Trump administration delayed implementing the regulations. It reopened the comment period and received new comments from both the insurance industry and claimants' representatives.
7. *See* Claims Procedure for Plans Providing Disability Benefits, 81 Fed. Reg. at 92341 (amending 29 C.F.R. §2560.503-1(g)((1)(vii)(D)) (claimants must be provided with notification of their right to receive all "relevant" documents). For the definition of "relevant," see 29 C.F.R. §2560.503-1(m)(8).
8. Claims Procedure for Plans Providing Disability Benefits, 80 Fed. Reg. at 72014.
9. Claims Procedure for Plans Providing Disability Benefits, 81 Fed. Reg. at 92319.
10. 29 C.F.R. §2560.503-1(b)(7) (2018).
11. *See, e.g.*, *Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105 (2008) (recognizing conflicts of interest when same party is responsible for funding claims and paying claims); *Demer v. IBM Corp. LTD Plan*, 835 F.3d 893 (9th Cir. 2016) (extending conflict analysis to insurer's choice of claim consultants); *Montour v. Hartford Life & Acc. Ins. Co.*, 588 F.3d 623 (9th Cir. 2009) (identifying various aspects of conflicts that may have contaminated claim decision); *Maiden v. Aetna Life Ins. Co.*, 2016 WL 81489, at *2 (N.D. Ind. Jan. 6, 2016) ("Aetna provided Maiden's file to two 'independent' consultants. . . . I put quotations marks around the word 'independent' because one might reasonably wonder just how independent the reviewers—Dr. Malcolm McPhee and Dr. Leonard Schnur—really are. Their bread has been buttered by Aetna before; each of them has been hired by Aetna multiple times to conduct these kinds of disability reviews.").
12. 29 C.F.R. §2560.503-1(g)(1).
13. 42 U.S.C. §423(d)(1)(A)) (2017).
14. Claims Procedure for Plans Providing Disability Benefits, 81 Fed. Reg. at 92322.
15. 29 C.F.R. §2560.503-1(g)(1)(vii)(C).
16. *See, e.g.*, *Jewell v. Life Ins. Co. of N. Am.*, 508 F.3d 1303 (10th Cir. 2007); *Orndorf v. Paul Revere Life Ins. Co.*, 404 F.3d 510 (1st Cir. 2005); *Perlman v. Swiss Bank Corp. Comprehensive Disability Prot. Plan*, 195 F.3d 975, 981–82 (7th Cir. 1999) ("[d]eferential review of an administrative decision means review on the administrative record").
17. 29 C.F.R. §2560.503-1(h)(4).
18. Claims Procedure for Plans Providing Disability Benefits, 81 Fed. Reg. at 92324–25.
19. Claims Procedure for Plans Providing Disability Benefits, 81 Fed. Reg. at 92325.
20. 134 S. Ct. 604 (2013).
21. 29 C.F.R. §2560.503-1(j)(4)(ii).
22. *See, e.g.*, *Heimeshoff*, 134 S. Ct. 604.
23. Claims Procedure for Plans Providing Disability Benefits, 81 Fed. Reg. at 92327.
24. 29 C.F.R. §2560.503-1(o). This rule's purpose was to ensure that all claimants, regardless of ethnicity or national origin, receive communications they can understand so they can act promptly to protect their rights.
25. 538 U.S. 822 (2003).
26. Claims Procedure for Plans Providing Disability Benefits, 81 Fed. Reg. at 92331.