LEGAL UPDATE

DOL Issues Final Regulations Regarding Claims Procedures for Disability Benefits

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Although rarely if ever a high-profile item, there is no question that long-term disability cases are the most frequently litigated of ERISA claims. While excessive fee litigation against 401(k) plans and stock-drop cases receive the headlines, a study of ERISA cases filed between 2006 and 2010 concluded that cases involving long-term disability benefits accounted for 64.5 percent of benefits litigation, whereas health care litigation and pension plan

litigation accounted for only 14.4 percent and 9.3 percent, respectively. This large volume of cases suggested that there may have been issues with the processing of long-term disability claims. In 2012, the Department of Labor's independent advisory group, the ERISA Advisory Council, urged the DOL to re-examine the claims procedures for disability benefits. In response, in November 2015, the DOL issued proposed regulations dealing with the claims procedures for disability benefit plans, which were intended to strengthen the procedural protections and safeguards for disability benefit claims by following in large measure the claims procedures for certain group health plans under the Affordable Care Act. The final regulations have an effective date of January 18, 2017, two days before the inauguration and an applicability date of claims for disability filed on or after January 1, 2018. This article focuses on two aspects of the final regulations.

One of the issues addressed in the final regulations was the treatment of contractual limitations periods for challenging denials of disability benefits claims. In 2013, in *Heimeshoff v. Hartford Life and Accident Ins. Co.*, the United States Supreme Court upheld the use of contractual limitations periods in plan documents and insurance contracts, which may override otherwise applicable state law. Addressing this issue in the preamble to the final regulations, the DOL indicated that Section 503 of ERISA requires that a plan afford a plan participant a reasonable opportunity to any plan participant whose benefit claim has been denied for a full and fair review of that denial by the relevant plan fiduciary. In the DOL's view, a claims procedure would not satisfy this ERISA statutory requirement if the plan included a contractual limitation period that expired before the review was concluded. Second, the final regulations add a requirement that the notice of an adverse benefit determination on review must include a description of the applicable contractual limitations period and its expiration date.

The final regulations also addressed the deemed exhaustion of a plan's claims and appeals processes. The final rule provides that if a plan fails to adhere to all of the requirements of the claims procedure regulation, the claimant would be deemed to have exhausted his or her administrative remedies, and therefore could proceed to court. There is an exception to this general rule mirroring the applicable standard for group health plans under the Affordable Care Act. The limited exception applies only if the violation is: (1) *de minimis*; (2) nonprejudicial; (3) attributable to good cause or matters beyond the Plan's control; (4) arises in the context of a good faith exchange of information; and (5) not reflective of a pattern or practice of noncompliance. That is, the exception is much stricter than a "substantial compliance" section.

From the perspective of a plan administrator or an insurance company interpreting a long-term disability plan, the likely effect of this rule is the loss of having a court review the determination on an arbitrary and capricious standard of review. While courts frequently assert that the arbitrary and capricious standard does not mean that a plan's decision will be rubber-stamped, and plan administrator's decisions are reversed by courts under that standard, it is a very low standard to satisfy, and almost all benefit plans have so-called *Firestone* language to ensure that this standard of review applies. While the DOL does not have the authority to determine the standard that a court should apply in reviewing a plan administrator's decision, the final regulations state that if a participant proceeds to court following a plan's failure to follow all of its claims procedures, "the claim or appeal is deemed denied on review without the exercise of discretion by the appropriate fiduciary."

It will be interesting to see how this regulation plays out in practice. In the preamble, the DOL noted that a number of commentators objected to the rule on the basis that it would encourage claimant's to circumvent a plan's claims and procedures, by seeking remedies in court in the event of insignificant missteps. The DOL disagreed, but simply stated its view that the typical participant pursuing a disability benefits claim in the context of a full and fair review, would seek to go to court based upon such insignificant violations. The typical participant probably would not take such action, but his or her counsel, in the context of zealous advocacy, will likely look for any advantage to deprive a plan administrator of the arbitrary and capricious/abuse of discretion standard of review.

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