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The Disability Insurance Team at Eric Buchanan & Associates helps individuals nationwide who have been denied disability insurance benefits and employee benefits. Our insurance and employee benefits team helps people apply for, or fight denials of, disability insurance benefits, life insurance, health insurance, and similar insurance benefits.

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ERISA REGULATIONS - THE OLD, THE NEW AND THE NEW NEW: PART 1 - BY ERIC L. BUCHANAN

Insurance policies provided through work almost always fall under ERISA.[1] This includes health insurance, life insurance, long-term disability insurance (LTD), accidental death and dismemberment insurance, and other similar benefits.

When an insurance policy falls under ERISA, any dispute about the claim is not litigated as a normal insurance contract case under state law. Instead, ERISA insurance claims are litigated under very different and challenging federal rules. One of the special rules about ERISA benefits is that the U.S. Department of Labor issues regulations governing how employees and insurance companies (and other ERISA administrators) must deal with each other during the ERISA claim process. The ERISA claims regulations were first issued in the late 1970s and were updated significantly in 2000. The regulations were updated again recently, with new additions to the regulations effective for claims filed after April 1, 2018.

This first part of a two-part article discusses the ERISA claims regulations generally and how to determine which version applies. The second part will cover the changes in the newest version of the regulations effective for those claims filed after April 1, 2018.

Which Version of the ERISA Claims Regulations Applies?

One part of understanding the regulations is determining which version applies—the "old" version applies to only a few remaining claims, the "new" version applies to most currently-active claims, and the "new new" version will begin applying to claims filed after April 1st of 2018.

The regulations issued by the Secretary of Labor were first issued in 1977, were updated through 1984, and then were not updated again until 2000[2]. The regulations were overhauled in the 2000 version regulations and are referred to in this paper as the "new" regulations or the "2000 regulations". The new regulations are effective for most types of claims filed after January 1, 2002. 29 C.F.R. § 2560.503-1(o) (group health claims were covered under the 2000 regulations effective January 1, 2003.)[3] The regulations were amended again on November 29, 2017, with new provisions taking effect for claims filed after April 1, 2018;[4] this newest version is referred to as the "new new regulations" or the "2018 regulations."

Most older claims for life insurance, health insurance, and similar claims are covered under the new regulations or, if filed since April 1, 2018, the new new regulations. But, it is important to understand that some older LTD claims might still be covered under the old regulations if the original claim was filed before January 1, 2002. Most commonly, the old regulations will apply if a person originally filed for benefits before January 1, 2002, was paid benefits for many years, and was only recently cut off.

For instance, in *Knight v. Provident Life*, Mr. Knight was found disabled by Unum and began receiving benefits in 2000. *Knight v. Provident Life & Acc. Ins. Co.*,

No. 3:12-CV-01226, 2014 WL 1280278, at *9 (M.D. Tenn. Mar. 27, 2014). Unum then cut off Mr. Knight's benefits in 2012. *Id*. Mr. Knight's long-term disability plan stated that he had 90 days to appeal this denial of benefits. *Id*. However, Unum argued that the old regulations applied, because the old regulations allowed an insurance company to give a claimant only 60 days to apply. *Id.* The court agreed that the old regulations would have applied to a claim that had originally been filed in 2000. *Id*. In this particular case, though, Unum's own plan terms controlled over the regulations since Unum's plan gave Mr. Knight more time to appeal. *Id*.

What is Covered in all Versions of the Regulations?

General Requirement of Reasonableness:

These regulations create a general requirement that claims procedures be reasonable. The regulations require that, "[e]very employee benefit plan shall establish and maintain reasonable procedures governing the filing of benefit claims, notification of benefit determinations, and appeal of adverse benefit determinations. . ." 29 C.F.R. § 2560.503-1(b).

Procedures for Filing a Claim Must be Reasonable and Must Follow the Plan:

To start a claim or application for benefits, a person must "request" plan benefits according to the procedures laid out in the plan. 29 C.F.R. § 2560.503-1 (b). Although claims procedures must be reasonable, plans otherwise have wide discretion in setting the procedures.

Under § 2560.503-1(b)(1), plan procedures will not be reasonable if they do not follow the rest of the ERISA regulations. Also, to be reasonable, the plan must provide a description of the claims procedures for a person to follow and those provisions must be in the plan's summary plan description. § 2560.503-1(b)(2). A plan may not "unduly inhibit or hamper" a claim or appeal (by, for example, charging a fee to make a claim or to file an appeal). § 2560.503-1(b)(3). A plan must allow a person to act through a representative. § 2560.503-1(b)(4). Benefits decisions must follow the applicable plan procedures and apply the plan procedures consistently. § 2560.503-1(b)(5).

Reasonable Procedures Can Not Require More Than Two Appeals but May Allow Additional "Voluntary" Appeals:

For claims for health insurance and LTD benefits, the regulations require that, after a person files a claim, the plan may not require more than two appeals before the person is allowed to take the claim to court under ERISA § 502(a). 29 U.S.C. § 502(a); 29 C.F.R. § 2560.503-1(c)(2). A plan can offer voluntary levels of appeal beyond that, but cannot prevent a person from taking the claim to court if they choose not to pursue the voluntary appeals. Also, if a claimant makes the voluntary appeal, any applicable statute of limitations is tolled until the voluntary appeal is completed. A voluntary appeal can only be offered after a person has completed the maximum two appeals. If offered, the plan must explain who will be deciding the voluntary appeal and whether the decision-maker of the voluntary appeal has any financial or personal interest in the outcome. Lastly, the plan may not charge any fees or costs as part of the voluntary appeal. 29 C.F.R. § 2560.503-1(c)(3)(i)-(v).

Limits on Arbitration:

A plan can offer arbitration as one of the first two appeals. However, a plan cannot require arbitration in addition to the two appeals. A plan cannot prevent a person from taking a claim to court under ERISA § 502 and instead require arbitration. 29 C.F.R. § 2560.503-1(c)(3)&(4).

Time Deadlines Under the Regulations:

Knowledge of the time deadlines is crucial to understanding the regulations. The time deadlines for filing an appeal and for the plan or insurance company to make a decision are spread throughout the regulations, but the highlights are summarized here.

Here are a few important rules to remember:

- There is a general set of deadlines, but there are more specific deadlines that apply to LTD and health insurance claims.
- If a claim was filed before January 1, 2002, the old 1984 regulations apply.
- Appeal times are a minimum, and the plan can allow for more time.

LTD Claims Under the New (2002) and New New (2018) DOL Claims Regulations (claims filed after January 1, 2002):

After the initial LTD claim is filed, the plan/claim administrator must make a decision within 45 days, which may be extended 30 days then another 30 days. 29 C.F.R. § 2560.503-1(f)(3).

If denied, the time to file an appeal must be reasonable, but not less than 180 days from the date of receipt of the denial. 29 C.F.R. § 2560.503-1(h)(2)(i), (h)(3)(i), and (h)(4).

The decision on appeal must be made within 45 days, which may be extended 45 days. 29 C.F.R. § 2560.503-1 (i)(1)(i) and (i)(3)(i).

LTD Claims Under the Old DOL Claims Regulations (claims filed before January 1, 2002):

An initial decision must be made within 90 days of the application being filed. This decision period can be extended 90 days. Old version of 29 C.F.R. § 2560.503-1(e)(3).

The time to file an appeal must be reasonable and related to the nature of the benefit, but not less than 60 days. Old version of 29 C.F.R. § 2560.503-1(g)(3).

The decision on appeal must be made within 60 days, which can be extended another 60 days. Old version of 29 C.F.R. § 2560.503-1(h)(1).

Deadlines for Other Types of Claims:

If you are helping a client with an ERISA claim for any type of benefits other than LTD, remember that different deadlines apply. For example, if you represent a client who has been denied life insurance benefits through a policy provided at work, the general deadlines under the regulations would apply.

The general rule is that, when a person files a claim for benefits, the plan has 90 days to make a decision but can give itself another 90 days to make a decision if it sends a written notice that it needs more time. 29 C.F.R. § 2560.503-1(f)(1). If denied, the claims procedures must allow a claimant 60 days to appeal. 29 C.F.R. § 2560.503-1(h)(2)(i). Once an appeal is filed, the decision-maker has 60 days to make a decision, which can be extended by another 60 days. 29 C.F.R. § 2560.503-1(i)(1)(i).

However, some types of claims other than LTD claims may not fall under these general deadlines, so make sure you are using the correct deadlines. For instance, health care claims have many different deadlines depending on the type of claim; if you are dealing with a health care claim read the regulations closely.

Calculating the Deadlines:

For the ERISA administrator or insurance company making a decision, the time deadlines set out above allow for a certain amount of time to make a decision but that time can be extended. Technically, the rule sets out that the administrator may take an additional 30 days "provided that the plan administrator both determines that such an extension is necessary due to matters beyond the control of the plan and notifies the claimant, prior to the expiration of the initial 45-day period." 29 C.F.R. § 2560.503-1(f)(3). The administrator may take an addition 30 days "[i]f, prior to the end of the first 30-day extension period, the administrator determines that, due to matters beyond the control of the plan, a decision cannot be rendered within that extension period."

In the real world, so long as the ERISA administrator or insurance company sends out a letter before the first deadline announcing it is taking more time, the administrator gets to extend its deadline. But, once the additional time has run, the administrator is out of time. If that happens, the claim is "deemed exhausted," as will be discussed below.

Also, remember that if a claim is denied and appealed to court, the court will only review the information in the record, which is the information submitted with the appeals and information the insurance company added. Remember, voluntary appeals are not always offered, so attorneys should do their best to submit all the evidence supporting the claim early, during the first appeal.

If a Claim Decision is Not Made on Time, it is Deemed Exhausted:

29 C.F.R. § 2560.503-1 (l) (This is a lower case "L") sets out the remedy for claimants if the plan fails to "establish and follow reasonable claims procedures":

(1) ***In general.*** Except as provided [in the 2018 "new new" regulations discussed in part 2] in the case of the failure of a plan to establish or follow claims procedures consistent with the requirements of this section, a claimant shall be deemed to have exhausted the administrative remedies available under the plan and shall be entitled to pursue any available remedies under section 502(a) of the Act on the basis that the plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

If the plan or insurance company fails to make a decision on time or violates the regulations in some other significant way, the claim is deemed exhausted and claimant has the right to take the case to court immediately.

Administrators and Insurance Companies Must Communicate with Claimants:

Another theme of the ERISA claims regulations is that, as part of a "reasonable" claims process, ERISA administrators and insurance companies must communicate with claimants about their claims. For example, the regulations provide a laundry list of information that must be included in a denial of benefits. See, e.g. 29 C.F.R. § 2560.503-1(g)(1) (a benefit decision must be in writing, and must include, in language that should be understood

by the claimant, such things as the specific reason for the denial, specific plan provisions relied on, a description of additional information needed, etc.). A similar list at 29 C.F.R. § 2560.503-1(j) sets out what must be in a denial letter. The regulations also require the administrator or insurance company to offer to provide the claimant a copy of all the relevant documents as defined in 29 C.F.R. § 2560.503-1 (h)(2)(iii) and (m)(8).

End Notes:

[1] The Employee Retirement Income Security Act of 1974.

[2] ERISA was enacted in 1974 and became effective January 1, 1975. The first claims regulations were issued May 27, 1977 (42 FR 27426); were amended January 21, 1981; (46 FR 5884), and were amended again on April 30, 1984 (49 FR 18295). As explained above, the 1984 regulations still apply to claims filed before January 1, 2002, and healthcare claims filed before January 1, 2003, and are referred to in this paper as the "old" regulations.

[3] The "new" 2000 regulations were issued Nov. 21, 2000 (65 FR 70265) and July 9, 2001 (66 FR 35887).

[4] The 2016 regulations, or the "new new" regulations, were issued Dec. 19, 2016 (81 FR 92341) and Nov. 29, 2017 (82 FR 56566). The 2016 amendments were not a complete overhaul but only added a few additions to the existing regulations, primarily focused on disability claims. The amendments that make up the 2018 new rules are set out in 29 C.F.R. § 2560.503-1 (p)(3). The amendments originally were to take effect on or after January 1, 2018; however, the amendments were put on a temporary hold during the change of administrations, so these changes became effective only for claims filed after April 1, 2018. 82 FR 56566.

ERIC BUCHANAN & ASSOCIATES, PLLC: UPCOMING CLE SPEAKING ENGAGEMENTS

Eric Buchanan will be speaking at the following events:

- **October 17-20, 2018 - NOSSCR Social Security Disability Law Conference in San Francisco**
  Topics: ERISA Claims Regulations that Apply to LTD Claims
  ERISA Statutes of Limitations that Apply to LTD Claims

- **October 22-23, 2018 - International DI Society Annual Conference in St. Louis**
  Topic: Become your Client's Hero

- **November 2, 2018 - TTLA ERISA Subrogation & Health Care Reimbursement Workshop in Nashville**
  Topics: Introduction, Overview & Update of ERISA Subrogation & Reimbursement in the Sixth Circuit & at the Supreme Court
  How to Find out the Rules of the Game in an ERISA Subrogation Claim
  ERISA Preemption: So How Do You Tell if Your Client's Insurance Policy is Really Preempted by ERISA?
  The Fundamental Rules & Ethics of ERISA Subrogation & Reimbursement Claims
  A Step-By-Step Approach to ERISA Subrogation

- **November 7-9, 2018 - NBTA All Star Conference in New Orleans**
  Topics: The Business Of Disability Panel & Questions
  Long Term Disability Insurance and ERISA Benefits
  Strategies for Profitability - Diversification and Federal Court Appeals Panel & Questions

NEED A SPEAKER?

The attorneys at Eric Buchanan & Associates, PLLC are available to speak to your organization regarding ERISA long-term disability, group long-term disability, private disability insurance, ERISA benefits, denied health insurance claims and life insurance claims.

Eric Buchanan & Associates, PLLC is a boutique plaintiffs' firm located in Chattanooga, Tennessee. We help individuals nationwide obtain disability insurance benefits and other ERISA employee welfare benefits (such as life, health or disability benefits offered through work). Attorneys are our number one source of cases. If you have a client who could use our help, we would appreciate your referral.

Eric's disability and benefits team can help!

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Attorneys at Law

- ERISA Long-Term Disability
- Group Long-Term Disability
- Private Disability Insurance
- ERISA Benefits
- Denied Health Insurance Claims
- Life Insurance Claims
- Long-Term Care Claims

We appreciate the opportunity to work with you on any of these cases.
Contact our Intake Team at intaketeam@buchanandisability.com.

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