ERIC BUCHANAN AND ASSOCIATES

Eric Buchanan & Associates, PLLC
Attorneys at Law

ERISA & DISABILITY BENEFITS NEWSLETTER

ABOUT OUR FIRM

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.

For more information, visit our website at www.buchanandisability.com.

VOLUME 10, ISSUE 3, OCTOBER 2018

R. Chandler Wilson, Audrey Dolmovich, Hudson Ellis, Eric Buchanan

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

In our previous newsletter published in September 2018, we discussed the ERISA claims regulations applicable to insurance and similar benefits provided at work, such as life insurance, long-term disability insurance (LTD), and health insurance.

In this second part of the article, we discuss the latest changes to the ERISA claims regulations. The new changes were published in 2016 but are only effective for claims filed after April 1 of 2018. Attorneys and claimants will begin to see more and more claims that fall under this latest set of regulations.

What's New in 2018?

As discussed in part 1, the ERISA regulations were overhauled and re-written in 2000, effective in 2002 (these were referred to as the "new" regulations in part 1). The regulations were tweaked and re-issued in 2016, to be effective April 1, 2018. These latest "new new" regulations did not change the timing, notice, and information requirements discussed in part 1. The new new regulations did add several important requirements, mostly applying to LTD claims.

Plans Must Ensure the Impartiality of Decision-Makers and Experts:

To further ensure that claims processes are "reasonable", 29 C.F.R. § 2560.503-1(b) was amended to address inherent bias in the decision-making process. When insurance companies pay benefits, they usually pay with their own money. It is not surprising, therefore, that insurance companies have been accused of rewarding their decision-makers for denying claims and hiring doctors and vocational experts based on the likelihood that they will help support a decision to deny benefits. To address this intrinsic bias, section (b) now declares:

> (7) In the case of a plan providing disability benefits, the plan must ensure that all claims and appeals for disability benefits are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. 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.

Because the amendments to the regulations are so new, there is little law addressing this mandate.

Presumably, however, this will encourage courts to allow plaintiffs greater discovery about insurance companies' biases.

Plans and Insurance Companies Must Address Treating and Examining Doctors' Opinions, the Opinions of Their Own Experts Favorable to the Claimant, and the Decision by the Social Security Administration:

The old and new regulations required plans to communicate with claimants, but the new new regulations require even greater communication. Specifically, the new new regulations in 29 C.F.R. § 2560.503-1(g) require plans to address in the initial benefits decision:

> (vii) In the case of an adverse benefit determination with respect to disability benefits [the notice must contain]-
>
> (A) A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
>
> (i) The views presented by the claimant to the plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;
>
> (ii) The views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
>
> (iii) A disability determination regarding the claimant presented by the claimant to the plan made by the Social Security Administration;

Note that this rule does not require significant weight be given to treating or examining doctors, nor that any special weight be given to the Social Security Administration's decision. It does, however, require the decision-maker to address that information.

Plans and Insurance Companies Must Explain the Time Limit to Go to Court:

One of the most important changes in the 2018 amendments is requiring that plans and insurance companies provide an explanation and a date certain for any deadline to take a case to court.

ERISA plans can include terms that limit the time to take a case to court, and that language is enforceable, even if the time can be running while a claimant is going through the mandatory administrative review process. *See, generally*, *Heimeshoff v. Hartford Life & Acc. Ins. Co.*, 571 U.S. ___, 134 S. Ct. 604, 610 (2013).

The regulation addressing what must be set out in a final denial decision on appeal, at 29 C.F.R. § 2560.503-1 (j)(4)(ii), explains:

> (ii) In the case of a plan providing disability benefits, in addition to the information described in paragraph (j)(4)(i) of this section [requiring a description of any voluntary appeals], the statement of the claimant's right to bring an action under section 502(a) of the Act shall also describe any applicable contractual limitations period that applies to the claimant's right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim.

This is one of the most useful additions to the regulations, because calculating the time to take a case to court can be very complicated and can require reading and interpreting multiple policy provisions. And, historically, insurance companies have used the complicated rules to play the "gotcha" game with claimants.

Claims Decisions Must be Written in a Way That is Understandable:

Another addition to 29 C.F.R. § 2560.503-1 (j), which sets out what must be in an appeal denial, is section (7) requiring that decisions be written in understandable language. It states:

> (7) In the case of an adverse benefit determination on review with respect to a claim for disability benefits, the notification shall be provided in a culturally and linguistically appropriate manner . . . .

Significant Violations of the Regulations Can Now Have Consequences:

Perhaps the most interesting addition in the 2018 new new regulations is the attempt by the Department of Labor to put some teeth into the requirements that the decision making process be reasonable. The regulation dealing with the "failure to establish and follow reasonable claims procedures," at 29 C.F.R. § 2560.503-1 (l) (this is the lowercase "L" again), has been expanded to add an additional consequence.

Before the new new regulations, a violation of the regulations or an unreasonable claims practice, such as missing the time to make a decision, resulted in the claim being deemed exhausted. Once a claim is deemed exhausted, a claimant may immediately take the claim to court. Now, in addition to being able to go straight to court, when there, the review by a court will be as if the fiduciary failed to exercise discretion, which should result in the review being *de novo*.

Further, it will not be good enough for plans to say they substantially complied with the regulations, which has long been their defense; rather, the regulations now require that they "strictly adhere" to "all the requirements" of the claims regulations. Specifically written for LTD claims and other claims providing disability benefits, the first part of the new section says:

> (2) Plans providing disability benefits.
>
> (i) In the case of a claim for disability benefits, if the plan fails to strictly adhere to all the requirements of this section with respect to a claim, the claimant is deemed to have exhausted the administrative remedies available under the plan, except as provided in paragraph (l)(2)(ii) of this section. Accordingly, the claimant is 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 a claimant chooses to pursue remedies under section 502(a) of the Act under such circumstances, the claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary.

29 C.F.R. § 2560.503-1(l)(2)(i).

But wait, there's more. Unfortunately, when a "plan fails to strictly adhere to all the requirements" of the ERISA claims regulations, the plan may be able to avoid this part of the regulations if the violation was "de minimis." The next part reads:

> (ii) Notwithstanding paragraph (l)(2)(i) of this section, the administrative remedies available under a plan with respect to claims for disability benefits will not be deemed exhausted based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to the claimant so long as the plan demonstrates that the violation was for good cause or due to matters beyond the control of the plan and that the violation occurred in the context of an ongoing, good faith exchange of information between the plan and the claimant. This exception is not available if the violation is part of a pattern or practice of violations by the plan. The claimant may request a written explanation of the violation from the plan, and the plan must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the administrative remedies available under the plan to be deemed exhausted. If a court rejects the claimant's request for immediate review under paragraph (l)(2)(i) of this section on the basis that the plan met the standards for the exception under this paragraph (l)(2)(ii), the claim shall be considered as re-filed on appeal upon the plan's receipt of the decision of the court. Within a reasonable time after the receipt of the decision, the plan shall provide the claimant with notice of the resubmission.

29 C.F.R. § 2560.503-1(l)(2)(ii).

Let's break down how this might work: First, a claimant shows that the ERISA plan or insurance company violated the rules. The insurance company or plan cannot defend such an accusation by claiming they "substantially complied." Instead, the plan or insurance company will claim that the violation of the claims regulations was "de minimis." The plan or insurance company would then need to show that the violation(s) did "not cause, and are not likely to cause, prejudice or harm to the claimant." The plan or insurance company would also have to demonstrate that "the violation was for good cause or due to matters beyond the control of the plan and that the violation occurred in the context of an ongoing, good faith exchange of information between the plan and the claimant." The regula-

tions do not set out what is good cause or good faith, so courts are going to have to wade through the facts of the claim process to determine if the "de minimis" exception is met.

Even if the violation were "de minimis", the plan cannot avoid the harsher result of the new new regulation, if the "violation is part of a pattern or practice of violations by the plan."

The rule gets more confusing, because it says the claimant "may" write a letter asking the plan or insurance company to explain why a violation of the rules should not trigger this provision. But, it does not say the claimant "must" do that, so does the claimant (or the representative) need to write such a letter or can the claimant take the case to court right away?

After the claimant takes the case to court and the whole back-and-forth above is laid out before the judge, the good news is that, even if the court finds the violation "de minimis," the claim is sent back and considered "re-filed" on appeal.

Because all these additions to the rules are so new, there have been virtually no cases reported on them yet. This will be very interesting to follow in the future.

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 and Update of ERISA Subrogation & Reimbursement in the Sixth Circuit and 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.

ERISA & DISABILITY BENEFITS NEWSLETTER

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!

ERIC BUCHANAN & ASSOCIATES, PLLC
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.

Eric Buchanan & Associates, PLLC
414 McCallie Avenue • Chattanooga, Tennessee 37402
PO Box 11208 • Chattanooga, Tennessee 37401
telephone (423) 634-2506 • fax (423) 634-2505 • toll free (877) 634-2506
intaketeam@buchanandisability.com
www.buchanandisability.com