Client ALERT

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Predispute Mandatory Arbitration Agreements and the New ERISA Claims Procedure Regulations

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In our August 2002 Client Alert entitled *Regulating ERISA Claims Procedures: New Rules for Handling Benefit Claims*, we explained that the chances of defeating most ERISA lawsuits can be greatly enhanced if a plan's claims procedure complies with the new ERISA claims procedure regulations and it is used effectively. Employers whose employees have signed predispute mandatory arbitration agreements that, among other things, require them to arbitrate health and disability plan claims may find it hard to comply with the new regulations because the regulations take the position that health and disability plans that mandate the final and binding arbitration of claims have "unreasonable" claims procedures, and the DOL has not issued any guidance on the issue of whether omnibus arbitration agreements that also apply to health and disability plan claims are "unreasonable." This Client Alert explores alternatives for addressing that concern.

The new regulations require employers and plan administrators to maintain "reasonable" claims procedures. If they do not, the regulations provide that claimants can ignore the claims procedures entirely, *i.e.*, they do not have to exhaust administrative remedies before suing. This likely would preclude a plan from receiving the benefit of the deferential standard of review that normally would have applied if the claimant had gone through its claims procedure. Rather, a court or arbitrator would review the claim and make an independent judgment. It is too early to tell whether courts will follow the regulations in this respect, but they may.

Employers with predispute arbitration agreements that require the arbitration of health and disability plan claims have two basic options: Wait to see how, if at all, the Department of Labor (DOL) and courts will apply the regulations to such agreements, or act now to eliminate mandatory final and binding arbitration of those claims. If an employer chooses to eliminate mandatory arbitration of health and disability plan claims, it likely would have to undergo a two-step process: (1) discontinue mandating arbitration in future agreements; and (2) select from the following implementation approaches as to existing agreements:

A. Modify existing arbitration agreements to discontinue the mandatory arbitration of health and disability plan claims. This may be more easily said than done because such agreements often require that amendments be in writing and signed by all parties to the agreement. As to such agreements, it may be hard to secure universal acceptance of the needed amendment, but widespread acceptance may be sufficient because it is not clear that any real harm would occur from noncompliance if an employer uses the waiver strategy described in the next paragraph as a back up.

B. Unilaterally waive the right to enforce existing arbitration agreements with respect to health or disability plan claims. An employer could inform all participants (*e.g.*, in SPDs) that it waives the right to enforce mandatory arbitration of ERISA health and disability plan claims to the extent prohibited by applicable law. This approach would be far more practical than seeking a formal amendment from each participant. Although a claimant potentially could challenge the effectiveness of this type of modification, with the intention of ultimately arguing that the plan's claims procedure is unreasonable, such a challenge is not likely to be successful. A court probably would not have much sympathy for a claimant who asserts that he or she is entitled to skip internal claims review and go straight to court because of the mere existence of a pre-claims-procedure-regulation arbitration agreement even though the employer has waived the right to enforce the agreement.

C. Continue enforcing existing agreements until the breadth of the new regulations' coverage is determined. This is an alternative for the adventurous. We do not believe that the DOL has the power to prohibit arbitration agree-

ments as to health or disability plan claims, especially in light of the Federal Arbitration Act's strong policy favoring arbitration and the absence of a provision in ERISA prohibiting arbitration. Therefore, we are dubious that an arbitration agreement would itself be unenforceable just because of the DOL's new regulations. However unlikely, the worst-case scenario for an employer who continues to enforce its arbitration agreements with respect to health and disability plan claims is that a court may find its claims procedure unreasonable, which effectively voids the procedure. This means that claimants could bring their ERISA disputes directly to court and that the plan would lose the deferential standard of review it otherwise would have been given.

We expect that the DOL's regulation will be challenged in litigation. Employers will contend that the DOL has erroneously conflated two distinct concepts and as a result attached an impermissible penalty (the loss of the exhaustion requirement and a deferential standard of review) on employers that have predispute arbitration programs. The DOL is failing to recognize that a benefit plan's internal claims procedure ends with the final decision of the plan administrator. That final decision may be challenged thereafter, in an ERISA lawsuit, but such a post-decision lawsuit is not part of, but rather is an attempt to override the result of, the internal claims process. In such a lawsuit, a court (usually a federal court sitting without a jury) decides the case. If arbitration is substituted for litigation, an arbitrator stands in the shoes of the judicial decisionmaker. Employers will argue that the choice of third-party arbitration over court litigation as the forum for the final and binding review of a decision following internal claims review cannot logically have anything to do with the deference due that earlier decision or the exhaustion requirement.

The new claims procedure regulations apply to disability plan claims submitted on or after January 1, 2002. Group health plans must be in compliance for claims submitted on or after January 1, 2003 (or, if earlier, the first day of the plan year beginning on or after July 1, 2002).

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