DISABILITY CLAIMS PROCEDURES

JANUARY 2018

HIGHLIGHTS

- Group health plans must comply with strict requirements for deciding benefit claims.
- According to the DOL, employees who request disability benefits deserve the same protections.
- The final rule adds new protections for disability benefit claims to make them more consistent with the rules for group health plan claims.

IMPORTANT DATE

April 1, 2018

The final rule's changes apply to disability benefit claims filed after April 1, 2018.

New Rules for Disability Claims Will Take Effect on April 1, 2018

OVERVIEW

On Jan. 5, 2018, the Department of Labor (DOL) announced that, effective **April 1, 2018**, employee benefit plans must comply with new requirements for disability benefit claims.

In 2016, the DOL released a **final rule** to strengthen the claims and appeals requirements for plans that provide disability benefits and are subject to the Employee Retirement Income Security Act (ERISA). The final rule was scheduled to apply to claims that are filed on or after Jan. 1, 2018. However, on Nov. 24, 2017, the DOL delayed the final rule for 90 days—until April 1, 2018—to give stakeholders the opportunity to submit comments on the final rule's benefits and costs.

According to the DOL, the information it received during the delay period did not justify modifying or rescinding the final rule. Thus, the final rule will take effect without change.

ACTION STEPS

ERISA plans that include disability benefits must comply with the new procedural protections, effective for claims that are submitted after April 1, 2018. Entities that administer disability benefit claims, including issuers and third-party administrators, will need to revise their claims procedures to comply with the final rule.

Lawley

ERISA Requirements

Section 503 of ERISA requires every employee benefit plan to:

- Provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the **specific reasons** for the denial, written in a manner calculated to be understood by the participant; and
- Afford a reasonable opportunity to any participant whose claim for benefits has been denied for a **full and fair review** by the appropriate named fiduciary of the decision denying the claim.

"Disability benefits are a lifeline for workers who are unable to work after becoming disabled. Claimants deserve to know how decisions are made. They and their families should also have confidence that the process and procedures are not biased against them." – Phyllis C. Borzi, former EBSA Assistant Secretary

The DOL first adopted claims procedure regulations for employee benefit plans in 1977. In 2000, the DOL updated its claims procedure regulations by improving and strengthening the minimum requirements for employee benefit plans, including plans that provide disability benefits. Effective for plan years beginning on or after Sept. 23, 2010, the Affordable Care Act (ACA) amended ERISA to include enhanced internal claims and appeals requirements for group health plans.

Additional Protections for Disability Claimants

The final rule requires that plans, plan fiduciaries and insurance providers comply with additional procedural protections when dealing with disability benefit claimants. The final rule includes the following requirements for the processing of claims and appeals for disability benefits:

- ***Improvement to Basic Disclosure Requirements***: Benefit denial notices must contain a more complete discussion of why the plan denied a claim and the standards used in making the decision.
- ***Right to Claim File and Internal Protocols***: Benefit denial notices must include a statement that the claimant is entitled to receive, upon request, the entire claim file and other relevant documents. Benefit denial notices also have to include the internal rules, guidelines, protocols, standards or other similar criteria of the plan that were used in denying a claim, or a statement that none were used.

What is a disability benefit? A benefit is considered a "disability benefit" if the claimant has to be disabled in order to obtain the benefit. It does not matter how the benefit is characterized or whether the plan as a whole is a retirement plan or a welfare plan. If the claims adjudicator must **make a determination of disability** in order to decide a claim, the claim must be treated as a disability claim for purposes of the DOL's claims procedures.

- ***Right to Review and Respond to New Information Before Final Decision***: The final rule prohibits plans from denying benefits on appeal based on new or additional evidence or rationales that were not included when the benefit was denied at the claims stage, unless the claimant is given notice and a fair opportunity to respond.
- ***Avoiding Conflicts of Interest***: Plans must ensure that disability benefit claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the people involved in making the decision. For example, a claims adjudicator or medical or vocational expert could not be hired, promoted, terminated or compensated based on the likelihood of the person denying benefit claims.
- ***Deemed Exhaustion of Claims and Appeal Processes***: If plans do not adhere to all claims processing rules, the claimant is deemed to have exhausted the administrative remedies available under the plan, unless the violation was the result of a minor error and other specified conditions are met. If the claimant is deemed to have exhausted the administrative remedies available under the plan, the claim or appeal is deemed denied on review without the exercise of discretion by a fiduciary and the claimant may immediately pursue his or her claim in court.
- ***Certain Coverage Rescissions Are Adverse Benefit Determinations Subject to the Claims Procedure Protections***: Rescissions of coverage, including retroactive terminations due to alleged misrepresentation of fact (for example, errors in the application for coverage), must be treated as adverse benefit determinations that trigger the plan's appeals procedures. Rescissions for nonpayment of premiums are not covered by this provision.
- ***Notices Written in a Culturally and Linguistically Appropriate Manner***: Similar to the ACA standard for group health plan notices, the final rule requires that benefit denial notices be provided in a culturally and linguistically appropriate manner in certain situations.

Delay of Final Rule

On Nov. 24, 2017, the DOL delayed the applicability of the final rule by 90 days—until April 1, 2018. According to the DOL, after the final rule was published, concerns were raised that its new requirements would impair workers' access to these benefits by driving up costs. The DOL concluded that, consistent with President Donald Trump's policy on alleviating unnecessary regulatory burdens, it was appropriate to give the public an additional opportunity to submit comments on the potential impact of the final rule.

On Jan. 5, 2018, the DOL announced that the final rule will take effect on April 1, 2018, without any changes. According to the DOL, it received over 200 letters from stakeholders regarding the final rule. However, the information it received did not establish that the final rule imposes unnecessary regulatory burdens or significantly impairs workers' access to disability insurance benefits.

Source: DOL's Employee Benefit Security Administration (EBSA)