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Regulatory Update

Disability Claim Regulations Take Effect April 1, 2018

Issue Date: March 2018

Introduction

The Department of Labor (DOL) has recently confirmed that final disability claims procedures regulations originally issued December 19, 2016 will take effect April 1, 2018. The rules will apply to disability related claims filed on or after that date. These regulations impose standards similar to what already applies for health plan claims rules (developed under the ACA) to any ERISA benefit determinations based on a participant's disability status. As such, they have potentially broad application to various ERISA plans. This Compliance Alert focuses on employer sponsored disability plans.

Background

There have been claims and appeals rules for disability plans subject to ERISA for many years. These new regulations are an attempt to increase transparency of the review process; prevent conflicts of interest with respect to claims reviews and denials; and align the disability claims process with the process that already applies to claims for group health benefits.

The effective date of the regulations was originally January 1, 2017, but the applicability date was delayed until January 1, 2018. In November of 2017, in response to President Trump's Executive Order 13777, the DOL delayed the applicability date until April 1, 2018. In early January of 2018, the DOL issued a statement indicating that the comments provided by stakeholders "did not establish that the regulations impose unnecessary burdens or significantly impair workers' access to disability benefits." The statement confirmed that the applicability date would remain April 1, 2018, and that the agency would not further delay nor change the regulations.

The regulations apply only to disability plans subject to ERISA. Most long-term disability (LTD) plans are subject to ERISA (assuming the employer who sponsors the plan is subject to ERISA). Many employers also offer short-term disability programs. Many STD plans satisfy the conditions of the DOL payroll practice exemption (DOL Reg. §2510.3-1(b)(2)). These STD programs would not be an ERISA disability plan and are not subject to the claims and appeals regulations. Note that if an STD plan is insured, it is subject to ERISA and these new regulations.

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What Do Employers Need to Do?

Employers generally rely on their insurance carrier or third-party administrator (TPA) to handle the claims appeal review process for disability coverage offered to employees. This will not change with the implementation of these new rules. The first thing the employer should do is to confirm with existing carriers, and administrators, that they are prepared to implement the procedures necessary to comply with these new rules. Employers should also confirm that the carrier or TPA will be sending any appeal notifications required by the new rules to affected participants.

Employers should also consider the following:

- Employers should review language in existing plan documents and summary plan descriptions (SPDs). Many employer documents do not include a detailed description of claims and appeals rules; rather, the employer documents refer to details contained in related insurance contracts and certificates. However, other employers may have incorporated more detailed claims and appeal rules information into their plan documents and SPDs.
- Any other documents outlining the plan's claims procedure (e.g., insurance certificate, benefits books, etc.) should be reviewed and updated as necessary to ensure that they describe plan procedures according to requirements under the new regulations.
- The notice requirements in the regulations are generally related to information that is provided to participants who are involved in filing a claims appeal. There are no new requirements to proactively notify participants of the new rules, other than updating relevant plan documents and SPDs described above. Most plans rely on the carrier or TPA to send participant notices required during an appeal. However, employers should also be sure they have processes in place to identify when non-English communications are required if the carrier or the TPA is not sending these notices.
- If a TPA is used, the employer should review its administrative services agreement with the TPA to clearly establish responsibility (and liability) for compliance.

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Summary

Note again that most employers rely on their disability insurance carrier or their TPA to manage most of the claims and appeal process, including the notices that must be sent to participants. However, the employer is ultimately responsible for the plans it sponsors, so it is imperative that employers work with carriers and TPA to understand their deliverables and to know when the employer may have some involvement in the claims appeals process. We have included a detailed summary of the new rules in Attachment 1.

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Attachment 1 – Detailed Overview of New Disability Claim Regulations

The regulations are intended to more closely align the claims procedures for disability plans with the requirements that exist for group health plans under the ACA.

Independence & Impartiality

Plan administrators must ensure that claims are adjudicated in a fair, impartial manner, and that administrators are not hired, terminated, compensated, or promoted based on the likelihood that the individual will support the denial of disability benefits.

Adverse Benefit Decision Notices – Content Requirements

Adverse benefit decision notices must include the following:

1. A discussion of the decision, including a detailed explanation of the basis for disagreeing (or not) with:
    - The health care professionals and vocational professionals who treated/evaluated the claimant;
    - The views of medical or vocational experts whose advice was obtained by the plan (regardless of whether the advice was relied upon in making the benefit determination); and/or
    - A disability determination made by the Social Security Administration.

(Note that the existing requirement also remains:If an adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, the notice must include either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge upon request.)

2. A description of the internal rules, guidelines, protocols, standards, or other criteria of the plan that were used in denying a claim (or a statement that none were used).

3. For a denial notice at the initial claims stage, a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claimant's claim for benefits.

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Right to Review New Information

Plans cannot deny a claim upon appeal using information that wasn't used in the initial determination (i.e., new or additional evidence or a new or additional rationale) unless the claimant is provided an opportunity, free of charge, to review and respond to the new information. To comply with this requirement, a plan must send the new or additional evidence or rationale automatically to the claimant as soon as it becomes available to the plan.

Disability Claims Timeframes

In general, disability claims timing requirements follow those that apply to group health plans, except that the timeframe for disability claims is "45 days" instead of "60 days."

Additional Statements

A plan's notification of benefit determination on review must include a statement describing any voluntary appeal procedures offered by the plan (and the claimant's right to obtain the information about such procedures), along with a statement of the claimant's right to bring action under Section 502(A) of ERISA. The statement of the claimant's right to bring action must include any applicable contractual limitations period that applies to that right, including the calendar date on which the contractual limitations period expires for the claim.

Strict Adherence to Claims Procedures

If plans fail to adhere to the claims processing rules, other than due to a violation resulting from a minor error, then the claimant is deemed to have exhausted the administrative remedies available under the plan and 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. If the court rejects the claimant's request for review, then the plan must treat a claim as re-filed on appeal upon the plan's receipt of the court's decision and must provide the claimant with a notice of the resubmission within a reasonable timeframe.

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Coverage Rescissions Are Adverse Benefit Determinations

The definition of an "adverse benefit determination" for plans providing disability benefits includes a rescission of disability benefits coverage that has a retroactive effective date, except in cases where a rescission is due to failure to timely pay premiums.

Notices to Be Written in a Culturally and Linguistically Appropriate Manner

Notices must be written in a culturally and linguistically appropriate manner. The same standards that apply to group health plan notices under the ACA apply to disability benefit denial notices. (If a disability claimant's address is in a country where 10% or more of the population is literate only in the same non-English language, benefit denial notices must include a prominent statement in the relevant non-English language about the availability of language services. And a verbal customer assistance process must be provided and described in writing in the non-English language upon request.)