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New Disability Claims Procedures

The U.S. Department of Labor (DOL) has announced that April 1, 2018 is the applicable date for employee benefit plans to comply with final rules for the management of disability benefit claims under the Employee Retirement Income Security Act (ERISA). As a result, the new DOL rules will apply to all claims for disability benefits under ERISA filed on or after April 1, 2018. The new procedures won't apply to non-ERISA arrangements where an insurer does not pay benefits. The new rules ensure, for example, that disability claimants receive a clear explanation of why their claim was denied as well as their rights to appeal a denial of a benefit claim, and to review and respond to new information developed by the plan during the course of an appeal. The rules also require that a claims adjudicator could not be hired, promoted, terminated, or compensated based on the likelihood of denying claims. Entities that administer disability benefit claims, including issuers and third-party administrators, will need to revise their disability claims procedures to comply with the final rules.

ERISA Claim Procedures - General

ERISA claims procedure regulations for employee benefit plans have long required that every ERISA plan (1) 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 (2) 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. 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, and the Affordable Care Act (ACA) amended ERISA in 2010 to include enhanced internal claims and appeals requirements for group health plans.

New Disability Claim Rules

The new DOL rules apply to any “disability” claim such as short term disability, long term disability, and life waiver of premium claims. Plans, plan fiduciaries and entities that administer disability benefit claims, such as insurers and third-party administrators, must comply with the following requirements for the processing of claims and appeals for disability benefits:

- 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.

- 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.
- Benefit denial notices must:
    - contain a more complete discussion of why the plan denied a claim and the standards used in making the decision.
    - include a statement that the claimant is entitled to receive, upon request, the entire claim file and other relevant documents.
    - 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.
    - be provided in a culturally and linguistically appropriate manner in certain situations (similar to the ACA standard for group health plan notices).
- Plans are prohibited 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.
- 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.

Next Steps

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. Some modest changes must be made to any documents that describe relevant disability claims procedures. Employers that maintain insured disability plans should communicate with the insurance carrier to obtain assurances that the new procedures will be applied and documented. If an insurer is acting as a third-party administrator (TPA) for a self-insured program, the employer should obtain assurances from the TPA that it will handle the new requirements and update the TPA agreements as needed to address these responsibilities. If a carrier provides plan summary materials as part of its administrative service only (ASO) services for a plan, revisions will be provided by the carrier. If a carrier is not contracted to provide that service for a self-insured plan, and the plan prepares its own materials, the plan will need to revise their materials. Note that the new procedures don't apply to non-ERISA short term disability arrangements, such as those that are merely payroll practices where the employer continues the employee's normal salary for some period of time while an employee is disabled.

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