Disability Claims Grow Up – Join the Real World

Back in December 2016, the United States Department of Labor released final regulations relating to disability claims under the Employee Retirement and Income Security Act (ERISA). Although originally due to become effective in January 2017, the DOL pushed off the effective date of the Final Rule until April 1, 2018.

Now, just around the corner, ERISA employers sponsoring disability plans should familiarize themselves with the provisions of these new rules which are intended to protect workers and disability plan participants who make claims under their employer-sponsored disability plans. Much like the DOL's revision of health care claims procedures prior to and through the Affordable Care Act (ACA), these Final Rules ensure that disability claimants receive a full and fair review of their disability claims as required under ERISA Section 503 by requiring that plan sponsors comply with additional procedural requirements. Employers should note that the Final Rules may affect more than just disability insurance and self-funded health plans; any ERISA-governed plans which include disability benefits, including certain defined benefit plans, 401(k)s, ERISA-covered 403(b)s, and top hat plans, are subject to the Final Rules. Only non-ERISA plans or arrangements are exempt from the new rules.

Traditionally, many short-term disability arrangements have been managed as simple payroll practices in which the employer continues the employee's normal salary for several weeks or months while the employee is disabled. The Final Rules require that the claims for disability benefits get the same complete review and consideration as medical claims and that employees eligible for such benefits get sufficient information about how their disability claims are processed or denied. It is the DOL's intention to provide enhanced transparency allowing claimants the last word in the claims process. In short, the Final Rules:

- Ensure that disability claimants receive a clear explanation of why their claim was denied as well as their right to appeal a denial of a benefit claim and to review and respond during the course of an appeal to any new or additional evidence the plan relied on in connection with the claim; and

- Require that a claims adjudicator cannot be hired, promoted, terminated or compensated based on the likelihood of denying claims.

This Final Rule applies to disability claims filed after April 1, 2018. Prior to April 2018, sponsors of disability plans and other plans containing such benefits should:

- Review claims provisions of plan documents and summary plan descriptions to conform with the requirements of the Final Rule. See the six (6) separate compliance requirements of the Final Rule below. NOTE: If you cover disability benefits under your self-funded medical plan managed by MedBen, the claims procedures described for covered medical benefits already meet the majority of the disability benefit claims procedure requirements.

- Review service agreements with any outsourced disability vendors to determine who has responsibility for compliance and liability for any failures to comply with the requirements in the Final Rule; and

- Review existing and updated internal or external provider disability claims process flows, materials, template materials, and other communications to ensure compliance with the Final Rule.

Employers will want to review and update their claims procedures for disability benefits in all their plans offering such options and make sure that they have updated language in their plan documents and summary plan descriptions. There are essentially six (6) parts to the new claims procedures for disability benefits. These changes look very much like those made as part of the ACA's claims and appeals enhancements to the group health plan claims procedures.

1. Independence and Impartiality – Efforts to Avoid Conflicts of Interest (Consistent with current ACA requirements)
    a. "Plans providing disability benefits must ensure that all claims and appeals for disability benefits are adjudicated in a manner designed to ensure the independent and impartiality of the persons involved in making the decision."
    b. The Final Rule requires that decisions regarding hiring, compensation, termination, promotion or similar matters with respect to any individual must not be made based upon the likelihood that the individual will support the denial of disability benefits.
        i. *For Example: A plan cannot provide bonuses based on the number of denials made by a claims adjudicator.*

2. Improvements to Disclosure Requirements – Explanation of Benefits (EOB) Requirements
    a. Adverse benefit determinations (sometime referred to as denial EOBs) on disability claims need to contain a discussion of the basis for disagreeing with the views of health care professionals or vocational professionals who treated the claimant, when the claimant presents those views to the plan. This is also relevant to when the plan consults a professional of this type in connection with the claimant's adverse benefit determination, without regard to whether this professional's advice was relied upon in making the decision.
    b. Internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making the adverse benefit determination must be provided with the adverse benefit determination notice (EOB).
    c. An adverse benefit determination at the initial claims stage must include a statement that the claimant is entitled to receive, upon request, documents relevant to the claim for benefits.

3. Right to Review and Respond to New Information Before Final Decision (Consistent with current ACA requirements)
    a. Plans must provide claimants, free of charge, with new or additional evidence considered, relied upon, or generated by the plan, insurer, or other person making the

benefit determination (or at the direction of such person) during the pendency of the appeal in connection with the claim.

b. Evidence or rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of an adverse benefit determination review is required to be provided to give the claimant a reasonable opportunity to address the evidence prior to that date.

4. Deemed Exhaustion of Claims and Appeals Processes (Consistent with current ACA requirements, but slightly stricter)
    a. If the plan fails to adhere to all the requirements in the Final Rule, the claimant would be deemed to have exhausted administrative remedies, with a limited exception where the violation was:
        i. *de minimis*;
        ii. non-prejudicial;
        iii. attributable to good cause or matters beyond the plan's control;
        iv. in the context of an ongoing good-faith exchange of info; and
        v. not reflective of a pattern or practice of non-compliance.
    b. In this case, the claimant has the right, upon request, to an explanation of the plan's violation and the plan has ten (10) days to respond. A claimant not satisfied with such explanation may file suit for benefits and may request that the court review the claim *de novo* – from the beginning without deference to any previous decisions.

5. Coverage Rescissions – Adverse Benefit Determinations
    a. Amends the definition of adverse benefit determination to include a rescission of disability benefit coverage that has a retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

6. Culturally & Linguistically Appropriate Notices (Consistent with current ACA requirements)
    a. If a claimant's address is in a county where ten percent (10%) or more of the population residing in that county are literate only in the same non-English language as determined in guidance based on American Community Survey data, notices of adverse benefit determinations to the claimant would have to include a statement in the applicable non-English language clearly indicating how to access language services provided by the plan.
    b. Additionally, plans must provide a customer assistance process with oral language services in the non-English language and provide written notices in the non-English language upon request.