



COMPLIANCE SERVICES **ALERT** LOCKTON BENEFIT GROUP



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Department of Labor Finalizes Regulation Revising Disability Plan Claims Procedures

The Department of Labor (DOL) recently published a final regulation revising the ERISA claims procedural requirements for disability plans. The new rules include additional protections to provide a full and fair review of disability claims. Disability claims have been the subject of extensive litigation. In an effort to ensure consistency, transparency and accountability in disability benefit claims determinations, the DOL published in November 2015 a proposed rule revising the claims procedures regulations. The final rule is substantially similar to the proposed rule.

Lockton comment: ERISA requires employee benefits plans to follow certain notice and appeals procedures when denying a claim for benefits. More stringent procedural requirements have traditionally applied to claims determinations by both group health plans and disability plans. The Affordable Care Act (ACA) amended the claims procedural requirements for group health plans, providing for additional protections and safeguards in processing health benefit claims. However, the ACA requirements did not apply to disability plans. With these new requirements, the DOL is attempting to create a more comprehensive “full and fair review” of disability claims, clearly hoping to reduce the need for participants to resort to litigation and reduce difficulties participants experience with delayed claims processing for critical income continuation.

What Changes Will the New Rules Require?

The final regulation amends current disability claims procedures by adding more procedural protections and safeguards. These new rules add requirements similar to those applicable to group health plan claims procedures under the ACA.

Lockton comment: The vast majority of employers offering disability benefits buy long-term disability insurance, in which case the burden of complying with the new claim processing regulations falls predominantly on the insurer.

Additionally, employers typically offer short-term disability benefits through a payroll practice (e.g., salary continuation). Payroll practices are not subject to ERISA, and so the new rules would not apply to those types of arrangements.

In accordance with the regulation, claims procedures for disability plans must incorporate the following requirements:

1. Claims and appeals must be adjudicated in a way that ensures independence and impartiality of those involved in the claims review process, including claims processors and medical experts, avoiding any conflicts of interest.

Lockton comment: The DOL emphasized that decisions regarding hiring, compensation, termination, promotion, or similar matters must not be based on the likelihood that the individual will support the denial of disability benefits.

2. Benefit denial notices must fully explain why the plan denied the claim and the standards behind the decision, including:
 - a. A discussion of the basis for disagreeing with any disability determination, presented by the claimant, made by the Social Security Administration (SSA) or the claimant's treating healthcare professionals, including vocational professionals.
 - b. A discussion of the basis for disagreeing with the views of medical or vocational experts whose advice was obtained on behalf of the plan, whether or not the advice was actually relied upon when making the benefit determination.
3. Any claim denial must include the internal rules, guidelines, protocols, standards or other similar criteria the plan relied upon in denying the claim or a statement that none exist.
4. If the initial adverse benefit determination was based on experimental or medical necessity criteria, the plan must provide an explanation of the scientific or clinical judgment the determination was based upon, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.
5. The claimants must be notified of their right to access and, upon request, obtain copies of any documents or records related to their claim.
6. Prior to a final decision on appeal, the claimants must be given a reasonable opportunity to review and respond to any new or additional evidence the plan relied upon in connection with the claim.

7. If plans fail to comply with the claims processing rules, the claimant is deemed to have exhausted the administrative remedies available under the plan and can seek immediate court review of the matter.

Lockton comment: The rules clarify that administrative remedies will not be deemed exhausted if the plan's violation is de minimis, non-prejudicial, attributable to good cause or matters beyond the plan's control, happens in the course of an ongoing good-faith exchange of information, and is not reflective of a pattern or practice of non-compliance on the part of the plan.

8. Coverage rescissions (i.e., a cancellation of disability coverage that has a retroactive effect) are treated as adverse benefit determinations, requiring the participant be given the opportunity to appeal the decision.
9. Notices and disclosures must be written in a culturally and linguistically appropriate manner similar to rules that currently apply to other benefits communications.

Lockton comment: If 10 percent or more of the population where the claimant resides are literate only in the same non-English language, applicable notices and disclosures must include a statement prominently displayed in the applicable non-English language detailing how the claimant can access language services.

When Do the New Rules Come Into Play?

The final rules apply to all claims submitted on or after Jan. 1, 2018.

Lockton comment: Most benefits rules apply on the first day of the plan year following the rule's effective date. However, these rules affect all plans as of Jan. 1, 2018, regardless of plan or contract year.

As stated above, the compliance burden of the new regulation will predominantly fall on insurers. However, as plan fiduciaries, employers will want to review insurance contracts to verify that the claims procedures have been updated in accordance with the new rules and periodically evaluate insurers and service providers to verify that the procedures are being followed.

Rory Akers, JD
Lockton Compliance Services

Lockton Benefit Group | 444 West 47th Street | Suite 900 | Kansas City | MO | 64112

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