Legislative Brief

HCR - DISABILITY CLAIMS PROCEDURES

December 2015

DOL's Proposed Rule for Claims Procedures for Plans Providing Disability Benefits

SUMMARY:

- The Department of Labor issued a proposed rule, modifying regulations pertaining to ERISA § 503, revising and improving the current procedural protections for workers who become disabled and make claims for disability benefits from an employee benefit plan.
- The proposed rule seeks to afford claimants of disability benefits a reasonable opportunity to pursue a full and fair review.
- The proposed rule will result in: 1) participants receiving benefits they might otherwise have been incorrectly denied; 2) alleviation of the financial and emotional hardship suffered by individuals when they lose earnings due to their becoming disabled; and 3) limiting the volume and constancy of disability benefits litigation.
- The Department of Labor will accept comments on the proposed rule until January 19, 2016. The final rule is expected to take effect 60 days after being issued in final form.

The purpose of the Department of Labor's (DOL) proposed rule is to align the requirements regarding internal claims and appeals for disability benefits with those for group health plans. The proposed rule affects plan administrators and participants and beneficiaries of plans providing disability benefits, and others who assist in the administration of these benefits, such as third party administrators.

Prior to the Affordable Care Act (ACA), group health plans sponsors and sponsors of ERISA-covered plans providing disability benefits were required to implement claims and appeal processes pursuant to ERISA § 503 and the regulations thereunder. The enactment of the ACA and the issuance of the implementing interim final regulations resulted in disability benefit claimants receiving fewer protections than group health plan participants. The proposed rule seeks to ensure that disability claimants receive the more stringent procedural protections that were established for group health plans.

Background

ERISA § 503 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
- To afford a reasonable opportunity to any participant whose claim for benefits has been denied for 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 disability benefits. In July 2010, the DOL published an interim final rule regarding the ACA enhanced claims procedures for group health plans.

On November 18, 2015, the DOL issued a final rule on the ACA's claims procedure requirements and issued the proposed rule on disability benefit claims procedures. Although fewer private-sector employees participate in disability plans than other types of plans, ERISA litigation is dominated by disability cases. The rise in disability cases is attributed to the aging workforce, and as a

result, insurers and plans are aggressively disputing claims because of the disability benefit costs. The proposed rule is meant to strengthen and improve the procedural rules governing the adjudication of disability claims.

Proposed Rule

The DOL's proposed rule seeks to add procedural requirements to ensure:

1. Independence and impartiality.

The proposed rule would align with the ACA group health plan requirements and provide that plans providing disability benefits would have to "ensure that all disability benefit claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision." This would also require 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.

2. Improvements to basic disclosure requirements.

To ensure claimants fully understand why their disability benefit claim was denied and so claimants are able to meaningfully evaluate the merits of pursuing an appeal, the requirements would be amended in the following ways:

1. Adverse benefit determinations on disability benefits claims would have to contain a discussion of the decision, including the basis for disagreeing with any disability determination by the Social Security Administration, a treating physician, or other third party disability determinations, to the extent that the plan did not follow those determinations;
2. Adverse benefit determinations would have to contain the internal rules, guidelines, protocols, standards or other similar criteria of the plan that were used in denying the claim; and
3. A notice of adverse benefit determination at the claim stage would have to contain a statement that the claimant is entitled to receive, upon request, relevant documents.

3. The right to review and respond to new information before a final decision.

The DOL believes the proposed rule will correct the procedural problems evidenced in litigation and provide claimants with the opportunity to respond at the administrative level to evidence and rationales, allowing for a full and fair review. To ensure this, the proposed rule requires:

1. Claimants to have a right to review and respond to new evidence or rationales during the pendency of the appeal;
2. Claimants are notified of and have any opportunity to respond to new evidence reasonably in advance of an appeal decision; and
3. Final denials at the appeals stage are not based on new or additional rationales unless claimants first are given notice and a fair opportunity to respond.

4. Exhaustion of claims and appeals processes.

The proposed rule would strengthen the exhaustion provision of the regulation by:

1. Replacing the existing standard for disability benefit claims with the more stringent standards under the ACA's updated claims procedure requirements;
2. In situations where the minor errors exception is inapplicable, the reviewing tribunal should not give deference to the plan's decision, but should review the dispute de novo (a court deciding the issues without reference to the legal conclusions made by the plan); and
3. Providing protection to claimants whose attempts to pursue remedies in court based on deemed exhaustion are rejected by the reviewing tribunal.

The minor errors exception involves a violation that is either:

- De minimis;

- Non-prejudicial;
- Attributable to a good cause or matters beyond the plan's control;
- An ongoing good-faith exchange of information; and
- Not reflective of a pattern or practice of non-compliance.

The claimant would also be entitled upon request, to an explanation of the plan's basis for meeting the minor error exception, so the claimant could make an informed decision about whether to seek immediate review. The proposed rule solidifies the DOL's view that if the plan fails to provide processes that meet the regulatory minimum standards, and does not qualify for the minor errors exception, the disability claimant should be free to pursue remedies available under Section 502(a) of ERISA on the basis the plan failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

5. Coverage rescissions—adverse benefit determinations.

The proposed rule would amend the definition of "adverse benefit determination" to include a rescission of disability coverage with respect to a participant or beneficiary. It would also define the term "rescission" to mean "a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely provide required premiums or contributions toward the cost of coverage." It would not prohibit rescissions, but rather would require plans to treat certain rescissions as adverse benefit determinations, thereby triggering the procedural rights under the regulation.

6. Culturally and linguistically appropriate notices.

The proposed rule contains safeguards for individuals who are not fluent in English and require adverse benefit determinations with respect to disability benefits to be provided in a culturally and linguistically appropriate manner. The safeguards include:

- Where a claimant's address is in a county where 10 percent or more of the population residing in that county, as determined by the American Community Survey data published by the United States Census Bureau, are literate only in the same non-English language, notices of adverse benefit determinations to the claimant would have to include a prominent one-sentence statement in the relevant non-English language about the availability of language services; and
- The plan provides a customer assistance process with oral language services in the non-English language and also provides written notices in the non-English language upon request.

Employer Benefits and Recommendations

There are substantial benefits for employers in implementing the new disability claims procedures, including, continuity between group health plan and disability claims processing, adverse benefit determinations, and appeals decisions. The inclusion of the new procedures will provide employees greater certainty that employers are handling disability claims determinations fairly and more efficiently. These processes should also assist in lessening potential litigation costs associated with disability claims.

Employers should be prepared to implement these enhanced disability claims procedures in 2016 by amending the plan document to reflect the new requirements. Generally, employers should look to amend their plans to reflect;

- Claims and appeals are adjudicated in a manner designated to ensure independence and impartiality of the persons involved in making the decision;
- Benefit denial notices contain a full discussion of why the plan denied the claim and the standards behind the decision;
- Claimants have access to their entire claim and are allowed to present evidence and testimony during the review process;
- Claimants are notified of and have an opportunity to respond to new evidence reasonably in advance of an appeal decision;
- Final denials at the appeals stage are not based on new or additional rationales unless claimants first are given notice and a fair opportunity to respond;

- If a plan does not adhere to the claims process rules, the claimant is deemed to have exhausted the administrative remedies available under the plan, unless the violation was a result of a minor error;
- Certain rescissions of coverage are treated as adverse benefit determinations, triggering the plan's appeals procedures; and
- Notices are written in a culturally and linguistically appropriate manner.

Repercussions for Failure to Follow Claims Procedures Requirements

As stated above, if a plan fails to establish or follow claims procedures consistent with the requirements, a claimant shall be deemed to have exhausted the administrative remedies available under the plan and shall be entitled to pursue any available remedies under Section 502(a) of ERISA on the basis that the plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim. The proposed rule seeks to amend the current rule by providing that any violation of the procedural rules would permit a claimant to seek immediate court action unless the violation falls under the minor errors exception.

The claimant would also be entitled upon request, to an explanation of the plan's basis for meeting the minor error exception, so the claimant could make an informed decision about whether to seek immediate review. If the violation does not fall within the minor errors exception, the proposed rule clarifies a court should not give deference to the plan's decision, but instead should review the dispute de novo.

Comments and Final Rules

The DOL will accept comments on the proposed rule until January 19, 2016. The final rule is expected to take effect 60 days after being issued in final form.

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