DOL Proposes New Claim and Appeal Rules for Disability Benefits

In late 2015, the Department of Labor (“DOL”) issued proposed disability claim regulations which, if finalized, will have a significant impact on claims administration procedures for plans subject to ERISA. Disability benefits under DOL regulations include any benefit where the claims adjudicator must make a determination of disability in order to decide a claim. As such, in addition to disability benefits such as short-term and long-term disability income, benefits such as a waiver of premium under a life insurance plan are subject to the DOL’s disability claim rules. ¹

The DOL’s disability claim regulations (both current and, if finalized, the proposed rules) apply to disability benefits that are insured or funded, but not to sick pay plans that qualify as a “payroll practice.” In general, if a benefit is paid solely from the employer’s general assets, then the plan would qualify as a “pay practice.” An employer may hire a third party such as an insurance company to review claims and provide advice to the employer on whether or not the individual is disabled as defined by the plan (often called an “advice to pay” contract) without jeopardizing the status of the benefit as a “payroll practice” as long as: (1) the employer has the responsibility to make the final determination to pay (or not pay) the benefits, and the plan is not funded or insured.

Background

The DOL issued final claim regulations for ERISA health and welfare plans – including disability benefits - in November 2000. Those regulations established minimum standards for the processing of claims and appeals for group health and disability benefits. The Patient Protections and Affordable Care Act (“PPACA”) substantially modified the claims and appeals requirements for non-grandfathered group health plans, but not disability benefits. The DOL’s proposed regulations released in late 2015 would modify the claim and appeal requirements for disability benefits.

When it released the proposed regulations, the DOL’s stated that its goal was to incorporate some of PPACA’s safeguards and procedural protections into the requirements for disability benefit. In furtherance of that goal, many of the changes being proposed for disability benefits are based on PPACA’s requirements for non-grandfathered health plans.

Major Changes

The DOL states that changes included in the proposed regulations seek to ensure that: (1) claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons making the

¹ Retirement plans, especially defined benefit plans that provide early benefits in the event of disability, would also be subject to these new rules. However, this Technical Bulletin does not discuss the proposed new rules as they apply to pension plans.
decision; (2) claim denials contain a full discussion of why the plan denied the claim; (3) claimants have access to their entire claim file and are allowed to present evidence and testimony during the appeal process; (4) claimants have an opportunity to respond to any new evidence in advance of an appeal decision; (5) final appeal denials are not based on new or additional rationales unless the claimant is given notice and a fair opportunity to respond; (6) if the plan does not follow the claim processing rules the claimant is deemed to have exhausted the administrative process under the plan (with an exception for certain minor errors); (7) rescissions of coverage are treated as a claim denial (i.e., adverse benefit determination) which triggers the plan’s appeal procedure; and (8) notices are written in a culturally and linguistically appropriate manner.

**Independence and Impartiality**

The DOL’s stated goal is to ensure that all disability benefit claims and appeals are adjudicated in a manner designed to insure the independence and impartiality of the person making the decision. The proposed regulations would require that decisions such as hiring, compensation, promotion and similar matters for a claims adjudicator or medical expert will not be based on the likelihood that the individual will support claims denials. For example, a plan would not be permitted to pay bonuses to claims adjudicators based on the number of denials made. Similarly, the plan would be expected to select a medical expert based on the individual’s professional qualifications rather than the medical expert’s reputation for outcomes in contested cases.

**Contents of Denial Notice**

Under current regulations, the notice of adverse benefit determination (i.e., denial notice) must include; the specific reason for the denial; a reference to the plan provision(s) on which the denial is based; a description of any additional information that may be needed to “perfect” the claim along with the reason the additional information is needed; a statement that a guideline or protocol was used in making the decision and that a copy is available free of charge; and, a description of the plan’s appeal process and time frames. Under the proposed regulations, the denial notice would have to contain the internal rules, guidelines, protocols or similar criteria of the plan that were used in denying the claim (or a statement that they do not exist.) The notice must also include a statement that the individual is entitled to receive, on request, a copy of all relevant documents.

The proposed regulations would also require the denial letter to contain a discussion of the decision, including the basis for disagreeing with any disability determination made by the individual’s treating physician, the Social Security Administration, or another third party disability payor where those determinations differ from the plan’s determination.

**Right to Review and Respond to New Information during Appeal**

Currently, claimants have a right to receive information about any new evidence or rationale used in a claim decision only after the claim has been denied upon appeal. Under the proposed regulations, the claimant would have the right to review and respond to new evidence or rationales during the appeal process. Specifically, prior to issuing a decision on an appeal the plan must provide the claimant with any new or additional evidence or rationale considered or generated by the plan in connection with the claim at no charge. The plan must also give the claimant a reasonable amount of time to respond to the new or additional evidence or rationale.

**Exhaustion of Claims and Appeals Processes**

It has been a long standing principle that a claimant must exhaust the plan’s appeal process before filing suit in federal court. Under the proposed regulations the claimant would be deemed to have exhausted the plan’s appeals process if the plan fails to adhere to all of the claim regulation requirements. However, there would be an exception for minor errors in procedure. In order to use the exception, the plan’s violation must be: (1) de minimis, (2) non-prejudicial, (3) attributable to a good cause or matters beyond the plan’s control, (4) in the
context of an ongoing good-faith exchange of information, and (5) not reflective of a pattern or practice of non-
compliance. In addition, the claimant would be entitled to request and receive an explanation of why the plan
believes that this exception applies.

In addition, in the event that the plan does not comply with all of the claims requirements, the standard of
review would be de novo rather than arbitrary and capricious. Under the arbitrary and capricious standard, the
court gives deference to the plan’s decision as long as the plan followed the required procedures and the plan’s
interpretation is reasonable. This standard is more favorable to the plan. Under the de novo standard, the court
reviews the claim without giving deference to the plan’s decision.

Coverage Rescission Would be an Adverse Benefit Determination

Rescission is a cancellation of insurance or coverage using a retroactive effective date. If the coverage
rescission is in connection with a claim for disability benefits, then the standard disability claim and appeal
requirements apply. However, in some cases coverage is rescinded when there is no claim for disability
benefits. For example, based on an audit the employer may determine that a particular employee is not eligible
for coverage under the disability plan, and as a result, retroactively cancel disability coverage for that employee.
Currently, there is no requirement that the plan give the employee an opportunity to appeal the decision to
rescind coverage where there is no claim for benefits. Under the proposed regulations, coverage rescission
would be considered an adverse benefit determination and the plan would be required to follow the claim and
appeal rules.

Culturally & Linguistically Appropriate Notices

Under the current rules, plans must provide required notices such as the notice of an adverse benefit
determination in a manner that is calculated to be understood by the average participant. However, the proposed
regulations are modeled on PPACA’s requirements for non-grandfathered group health plans and would require
notices to include a prominent one-sentence statement in the relevant non-English language about the
availability of language services, if the claimant’s address is in a county where 10 percent or more of the
population is literate only in the same non-English language. The plan would also be required to provide a
customer assistance process (such as a telephone hotline) with oral language services in the non-English
language and must provide written notices as well as claim and appeal assistance in that non-English language.
Currently, 255 U.S. counties satisfy the 10% threshold with Spanish being the non-English language in the
overwhelming majority of those counties. In 5 counties (in Alaska, Arizona, California, New Mexico and
Utah), the language involved is Chinese, Navajo or Tagalog. The full list of counties and non-English language
is updated annually. Click here to access the January 2016 list.

Impact on Employers

This rule is currently in proposed format and will not become effective unless and until it is finalized by the
DOL. Although no time frame has been provided, the comment period ended on January 19, so the DOL may
issue final regulations sometime later this year.

As a practical matter, most employers will be able to rely on their insurer to make any changes needed to
comply with requirements in the final regulations. Employers with disability plans that are not insured but are
funded may want to become familiar with the proposed regulations in order to be prepared when final
regulations are provided. The new rules would not apply to disability benefits – such as salary continuation –
that qualify as payroll practices.

Gallagher Benefit Services, through its compliance experts and consultants, will continue to monitor
developments on healthcare reform legislation and regulation and will provide you with relevant updated
information as it becomes available. In the interim, please contact your Gallagher Benefit Services Representative with any questions that you may have.

The intent of this Technical Bulletin is to provide general information on employee benefit issues. It should not be construed as legal advice and, as with any interpretation of law, plans sponsors should seek proper legal advice for the application of these rules to their plans.