DOL Finalizes Claims and Appeals Rules for Disability Benefits

In late 2016, the Department of Labor (“DOL”) issued final rules updating existing ERISA claims and appeals procedures for employee benefit plans providing disability benefits. Under DOL regulations, disability benefits 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 claims rules.  

The DOL’s disability claims 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 “payroll 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 (2) the plan is not funded or insured.

The final rules apply to all claims for disability benefits filed on or after January 18, 2018.

Background

The DOL issued final claims 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 proposed regulations modifying the claims and appeals requirements for disability benefits in late 2015. When it released the November 2015 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 benefits.

Major Changes from November 2000 Regulations

The DOL states that the changes included in the final rules 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 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

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1 Retirement plans, such 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 new rules as they apply to pension plans.
denials are not based on new or additional rationales, unless the claimant is given adequate notice and a fair opportunity to respond; (6) if the plan does not follow the claims processing rules then 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 appeals procedure; and (8) notices are written in a culturally and linguistically appropriate manner.

**Independence and Impartiality**

The final rules require that decisions such as hiring, compensation, promotion and similar matters for a claims adjudicator or medical expert are not based on the likelihood that the individual will support claim denials. For example, a plan is not permitted to pay bonuses to claims adjudicators based on the number of denials made. Similarly, a plan is 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. The final rules also added vocational experts to the list of individuals who must make decisions independently and impartially and also clarify that the independence and impartiality requirements apply to the plan even if the plan does not directly hire or compensate the individuals involved in making claim determinations.

**Contents of Adverse Benefit Determination (Denial) Notices**

Under the November 2000 regulations, a 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 appeals process and time frames. The final rules expand the content requirements by requiring that the denial notice automatically include information about the internal rules, guidelines, protocols or similar criteria used by the plan in denying the claim (or a statement that they do not exist), rather than a statement that the claimant may receive this information upon request. The final rules also require that the notice include a statement that the individual is entitled to receive, on request, a copy of all relevant documents.

The proposed regulations would have required the initial denial letter to contain a discussion of the denial 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 payer, where those determinations differ from the plan’s determination. The final rules omit the requirement to include a discussion of a disability determination from another third-party, but retain the requirement to discuss the plan’s disagreement with the attending physician and the Social Security Administration’s determination.

Moreover, under the final rules, the denial notice must also include an explanation of any scientific or clinical judgment that was used in making the claim determination as applied to the individual’s claim (or a statement that this information is available upon request at no charge.) A general statement that a scientific or clinical judgment was used will not be sufficient. The rules clarify that if a plan obtains advice from a medical or vocational expert in connection with an adverse benefit determination, the notice of adverse benefit determination must include a discussion of that advice, even if the advice was not relied upon in making the determination (for example, if the advice was inconsistent with the plan’s decision).

**Right to Review and Respond to New Information during the Claims Process**

The November 2000 regulations gave claimants the right to receive information about any new evidence or rationale used in a claims decision, but only after the claim had been denied on appeal. The final rules make it clear that during the appeals process the plan must automatically provide the claimant with any new or additional evidence that was considered, as well as, any new or additional rationale for a denial, at no charge.
The plan must provide this information as soon as possible and must give the claimant a reasonable amount of time to address the new evidence or rationale before the decision on the appeal is to be made. As part of this process, the plan must also consider any response made by the claimant to this new information as part of its decision-making process. The plan may not satisfy this requirement by providing the claimant with a notice that additional evidence (or rationale) was used and offer to provide that new information at no charge. Rather, the plan must automatically provide the claimant with the information at no charge.

The final rules contain an example of how this process should work. The example assumes the following: the plan denies a claim at the initial stage based on a medical report generated by the plan administrator; the claimant appeals the denial; and during the 45-day period that the plan has to make its decision on appeal, the plan administrator generates a new medical report. In this example, the plan must automatically furnish any new or additional evidence in the second report, including any evidence that may support the claim, to the claimant. The plan must furnish this information as soon as possible and in advance of the end of the 45-day period to provide the claimant with a reasonable opportunity to address the new/additional evidence. The plan must also consider any response from the claimant when making the decision on appeal. If the claimant’s response causes the plan to generate a third medical report with new/additional evidence, the plan would have to automatically furnish that information to the claimant and give the claimant sufficient time to respond. In short, the final rules view the appeals process as an interactive process.

**Exhaustion of Claims and Appeals Processes**

It has been a long standing principle that a claimant must exhaust the plan’s appeals process before filing suit in federal court. Under the final rules, the claimant is deemed to have exhausted the plan’s appeals process if the plan fails to adhere to all of the claims requirements. However, there is an exception for minor errors in procedure. In order to use the exception, the plan’s violation would have to 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 is entitled to request and receive an explanation of why the plan believes that this exception applies. The claimant may request a written explanation of any violation of the claims requirements from the plan. The plan must provide the explanation within ten days, and if the plan believes that the violation is de minimis (i.e., that the claimant must still exhaust the administrative process before filing suit), the plan must state its reason for that determination.

**Coverage Rescission Would be an Adverse Benefit Determination**

Rescission is a cancellation of insurance or coverage using a retroactive effective date (except for cancellations based on non-payment of premiums). If the coverage rescission is in connection with a claim for disability benefits, then the standard disability claims and appeals 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 final rules, coverage rescission is considered an adverse benefit determination and the plan is required to follow the claims and appeals rules.

**Time Limits for Appealing Denied Claims**

Under the current rules, a letter denying a claim on appeal must include a statement that the claimant may file suit. However, the current rules do not require such a statement in the initial claim denial. The final rules amend the current requirement and provide that all benefit denial letters - not just denials of appeals - must include a
statement that the claimant has the right to file a lawsuit. In addition, the final rules require that such letters must include information about any contractual time limits for filing a lawsuit and must provide the actual calendar date. Finally, the final rules require that the deadline for filing suit may not end before the conclusion of the plan’s internal appeals process.

**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 final rules, which are modeled on PPACA’s requirements for non-grandfathered group health plans, 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 at least 10 percent of the population is literate only in the same non-English language. The plan is also 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, claims and appeals assistance in that non-English language. Currently, there are a little over 260 U.S. counties that satisfy the 10% threshold with Spanish being the non-English language in the overwhelming majority of those counties. A listing of counties where 10% or more of the population is literate only in the same non-English language is updated annually and available on the CMS website (this is the same list that is used for PPACA). Click here to access the 2016 list. As of January 30, the 2017 list has not yet been made available.

**Impact on Employers**

For insured plans, insurers will need to make any changes needed to comply with requirements in the final rules. However, the final rules make it clear that the plan has a responsibility to take steps to ensure that insurers comply with the rules. Plans cannot just assume that the carrier will be in compliance, particularly in situations where there is information that may indicate a problem. For example, plans that receive complaints from claimants about a claim decisions may need to take a more active role. Moreover, plans that notice an unusual number of complaints or a pattern of practices that may not be appropriate may need to investigate further in order to comply with their obligations.

Employers with disability plans that are self-insured should become familiar with the final rules before the January 2018 effective date. Employers may not simply assume that a third-party hired to provide services, such as claims adjudication will be solely responsible for complying with the rules. Rather, self-insured employers may need to take steps such as including specific provisions in their service contract(s) and monitoring the performance of their third-party vendors on an ongoing basis.

Lastly, plan sponsors may also need to make changes in the documents used to administer their plans, such as the formal plan document, summary plan description, and relevant claim communication materials (e.g., the initial notice of adverse benefit determination and notice of adverse benefit determination following an appeal).

Gallagher Benefit Services, through its compliance experts and consultants, will continue to monitor legislative and regulatory changes that may impact your health and welfare benefits 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.