NEW PROPOSED CLAIM PROCEDURES FOR DISABILITY PLANS

In order to strengthen current claim rules, the Department of Labor (DOL) recently proposed new claim procedures for disability plans regulated by the Employee Retirement Income Security Act (ERISA). The new procedures would amend the rules in place since 2002. These procedural protections and disability plan safeguards are similar to those that apply to health plans under the Affordable Care Act (ACA).

This Benefit Advisor:

- Reviews the current ERISA claim and appeal procedures for disability plans
- Reviews changes proposed by the new regulations
- Clarifies the difference between pay practices and ERISA plans
- Provides action steps for employers

Because our population is aging, the DOL anticipates an increase in disability claims and litigation. It is concerned that this increase may motivate insurers and plans to dispute disability claims aggressively. For this reason the DOL has proposed changes to the current rules that will strengthen the claim review and appeal process. These proposed changes apply only to ERISA plans. They will not take effect until final regulations are published.

CURRENT ERISA CLAIM AND APPEAL PROCEDURES FOR DISABILITY PLANS

ERISA requires employers to follow very specific procedures for determining claims and reviewing claim appeals. In general, a participant must exhaust the plan’s claim process before suing for benefits under ERISA.

ERISA plans must abide by these claim rules. If employers insure their disability benefits, they largely rely on their insurance carriers to follow the rules. The DOL takes the position that insurers are responsible for

Continued on Page 2
deciding claims. The insurance carrier is considered the claims fiduciary. If the plan is self-funded, the employer typically relies on the Third Party Administrator (TPA) to follow the claim processing rules.

ERISA sets forth rules and time periods for determining claims and reviewing appeals. The starting point is a claim for benefits. A claim for benefits is a request for a plan benefit made using the plan’s reasonable procedures for filing claims. The plan must make a decision as soon as reasonably possible, but no later than 45 days after receiving a claim. Two 30-day extensions are available for disability claims when matters beyond the control of the plan arise. However, a plan must notify the claimant that it needs an extension before the end of the claim determination period. The notice must specify the matters beyond the control of the plan that prompt the need for the extension, any unresolved issues preventing a decision and any other required information. If the plan needs more information, it must give the claimant 45 days to provide that information. The notice must also include the specific date the plan expects to resolve the claim. If the plan requires a second 30 day extension, it must notify the claimant before the end of the first 30 day extension.

If a claim is denied, the claimant has at least 180 days to file an appeal and the plan has 45 days to respond. The appeals procedure must include a full and fair review of the claim and the reason for the denial. Plans have considerable flexibility in setting appeal procedures. The ERISA guidelines require a meaningful dialogue between plan administrators and their beneficiaries. A full and fair review means claimants can review all relevant documents and any other pertinent information.

When a claim is denied based on a medical judgment, including whether a particular treatment, drug, or other item is experimental, investigational or not medically necessary, the appeal procedures must require the claims fiduciary to consult with a health care professional appropriately trained in the relevant medical field. If a plan has two levels of appeal, it must use a different independent health care professional in each appeal level.

If a plan seeks advice from a medical or vocational expert in order to determine the claim, the plan’s appeal procedures must identify the expert, even if the plan did not rely on the advice in making its decision.

Summary Plan Description (SPD) wording is critical in claim determinations. Within the SPD, the plan must spell out the rules for determining claims and appeals. Plans should reserve the right to a deferential standard of review. If this standard is reserved, then a plan decision will be overturned only if the decision was arbitrary and capricious or it abused the discretion allowed.

When appeals are exhausted, claimants can sue for benefits under ERISA. The DOL also allows arbitration or other ways to resolve disputes. Arbitration must follow in a reasonable time period and meet other procedural requirements. Even if arbitration is mandatory, the result may not be binding. The regulations allow a claimant to challenge an arbitrator’s decision in court under ERISA.

There are a number of potential consequences if a plan does not comply with the DOL claim procedure regulations. First, if a plan does not establish or follow claim procedures consistent with the DOL regulations, a claimant is considered to have exhausted administrative remedies. This means the claimant can sue for benefits under ERISA, without completing the appeals process. If a plan decision maker blatantly fails to follow the claim regulations procedures, a court may apply a “de novo” standard of review. This standard of review is far broader than the deferential standard of review.
The claim regulations for disability claims are complex. Employers need to be sure their insurance carriers or TPAs are following the required procedures.

**CHANGES PROPOSED BY THE NEW REGULATIONS**

The changes in these proposed rules are designed to lift the current claim disability standards to align more closely with health plan requirements. The ACA expanded participants’ health care claim and appeal rights. The DOL believes disability claimants deserve the same level of protection.

The new proposed claim regulations include the following six major changes:

1. **Plans will need to adopt procedures that ensure anyone making claim and appeal decisions is independent and impartial.** The new proposed regulations include new criteria for avoiding conflicts of interest for anyone making these decisions. The new rules will require that decisions on hiring, compensating, or terminating claims adjusters or medical experts must NOT be based on whether that person will deny disability benefits. For example, plans could not provide bonuses to claims adjudicators based on the number of denials. Also, a plan would not be able to contract with a medical expert based on the expert’s reputation for outcomes in contested cases rather than based on the expert’s professional qualifications.

2. **Denial notices will be required to fully explain the basis for denial and the standards behind the decision.** The proposed regulations add three new requirements for denial notices. First, denial notices would need to explain the decision and why the social security administration, the treating physician, or any other third party disability payer disagreed with the disability determination. Second, these notices would need to include the internal rules, guidelines, protocols, standards or other reasons for denying the claim. Third, the denial notice at the claim stage would need to state that the claimant can access relevant documents upon request. This change will allow claimants to fully understand why their disability claims were denied. What’s more, with this additional information, claimants could meaningfully evaluate the merits of pursuing an appeal. Claimants will need to have access to their entire claim files and be permitted to present evidence and testimony during the review process.

3. **Claimants must be notified of and have an opportunity to respond to any new evidence in a reasonable time period before an appeals decision.** To make sure claimants have the right to a full and fair review of their claims, additional criteria will be added allowing them to review and respond to new evidence or new rationales the plan developed during a pending appeal. Before a decision on an appeal, the plan must send a disability claimant at no cost any new or additional evidence the plan considered or generated regarding the claim. In addition, the plan must send the claimant any new or additional reason for a denial. The claimant must have the opportunity to respond to new evidence or a new rationale. The DOL is requesting comments on how this right to review and respond would impact claim time periods. Final denials at the appeals stage could not be based on new or additional rationales unless claimants first are notified and given a fair opportunity to respond.

4. **Claimants would be considered to have exhausted administrative remedies if the plan fails to comply with the claims processing rules with limited exceptions.** If a plan does not comply with the claim or appeals process, the administrative remedies are deemed exhausted and the claimant can sue. The limited exceptions to this rule include circumstances where the violation was:
   a. de minimis
   b. non-prejudicial
c. attributable to good cause or matters beyond the plan’s control
d. in the context of an ongoing good-faith exchange of information
e. not reflective of a pattern or practice of non-compliance.

The new proposed rules also clarify that if a claimant’s administrative remedies are deemed exhausted and the claimant sues, the dispute should be reviewed under the de novo standard of review. Protections are also included if a claimant sues before exhausting administrative remedies. If a court rejects a claimant’s request for an immediate review because the situation would actually be considered one of the limited exceptions, the claim would be considered re-filed on appeal at the point the plan receives the court’s decision. Within a reasonable time after receiving the decision, the plan needs to notify the claimant that the claim has been resubmitted. At this point, the claimant has all the rights that any other claimant has under the appeal process.

5. Certain rescissions would be treated as claim denials, therefore triggering the plan’s appeal procedures.

For this purpose, rescission means the disability coverage has been canceled or discontinued retroactively. The rules allow coverage rescissions to be treated as denials whether or not there is an adverse effect on any particular benefit at that time. The definition of a rescission excludes termination because premiums were not paid on time.

6. Notices must be clear, concise and culturally appropriate. If a claimant lives in a county where 10 percent or more of the population speaks the same non-English language (based on American Community Survey data the United States Census Bureau publishes), the claim denial would have to include one sentence in that language explaining where to obtain a translation. Translation services might be available through a telephone hotline or notices written in the non-English language. Answers to questions and help with filing claims and appeals should be available in the claimant’s language.

The DOL has asked for comments from stakeholders on these new proposed rules. Specifically, it is seeking comments on a statute of limitations. ERISA does not specify how long a claimant has to file a civil suit after a final denial. Federal courts have generally looked to state laws to determine the appropriate time limit. State laws vary, but most clocks start when the final denial is delivered. Insurance contracts and plan documents often set limits that may override state law. The concern is that claimants may not read their documents and may not understand there is a time limit for filing a lawsuit.

DOL would like input on whether plans should provide claimants with a clear, prominent statement of any applicable time limit for filing suit after the final denial notice.

PAY PRACTICE OR ERISA PLAN

For the most part, insurance carriers and TPAs will be responsible for making changes to their claims and appeals procedures in regard to disability claims. For employers that self-fund short term disability benefits and manage the claims in-house, these proposed rules can impact that process.

These proposed changes may burden employers who self-fund their short-term disability plan. The DOL has an ERISA regulatory safe harbor for plans that are considered “payroll practices.” Plans that are considered payroll practices are NOT considered ERISA benefit plans (even if they would be if they were fully-insured). If your organization self-funds short term disability benefits, it is important to know whether your plan is considered an ERISA plan or an employer payroll practice.

You need to look at a number of key administrative processes:

- How are benefits paid? If the benefits are unfunded and paid from the employer’s general assets, the plan is likely to be considered a payroll practice.
• Will percentage of income replacement matter? Even if the plan only replaces a percentage of weekly income, such as 60 percent, it can still be considered a payroll practice.

• Does the employer use a vendor to administer claims? It doesn’t matter because the issue is how the plan is funded, not who administers it.

• Does the plan pay former employees? Paying benefits to former employees may require an employer to treat the short-term disability plan as an ERISA plan. This may be a concern if your organization has a long benefit period and formally terminates an employee during the benefit period. For example, a company may have a plan with a two-year benefit period. The company formally terminates disabled employees after 12 weeks of disability. This arrangement would be viewed as providing benefits to former employees. If this is the case, the plan would be subject to ERISA

If you are unsure whether your self-funded disability plan is an ERISA plan or a payroll practice, you should consult an attorney. If your plan is subject to ERISA, you must comply with all ERISA requirements, including these proposed changes to the claim rules, when they take effect.

**ACTION STEPS FOR EMPLOYERS**

The DOL requested comments on these changes. These changes will take effect 60 days after the final regulations are published in the Federal Register.

For the most part, insurance carriers will adopt these procedural changes for insured ERISA disability plans. Employers may need to update their SPDs, if the current wording is not broad enough to encompass the procedural changes.

Employers that self-fund short-term disability benefits will need to review their programs to determine whether the program would be considered a payroll practice or an ERISA plan. If your plan is a payroll practice, remove references to ERISA from the plan document. Also review your 5500 to make sure the short-term disability benefit plan is not listed as a benefit under the 5500. Courts have ruled that referring to ERISA under the payroll practices document will not necessarily bring the plan under ERISA. However, it does muddy the waters. It is best to make clear the payroll practice of providing self-funded short-term disability or continuing salary is not an ERISA plan benefit.

If your self-funded plan does not meet the payroll practice safe harbor, the plan will be considered an ERISA plan. In that case, you need to develop procedures to follow the claim review requirements. Also you will need to update those procedures when the final regulations are issued.

If you have any questions, please contact your Marsh & McLennan Agency Michigan Account Manager: **MMA**