COMPLIANCE BULLETIN

New Rules for Disability Benefit Claims May Be Delayed

HIGHLIGHTS

- Group health plans must comply with strict requirements for deciding benefit claims.
- A final rule from 2016 is scheduled to extend similar requirements to disability claims.
- The DOL has proposed delaying the final rule in order to evaluate its impact and consider alternatives.

IMPORTANT DATES

January 1, 2018
The final rule's changes are currently scheduled to apply to disability benefit claims filed on or after Jan. 1, 2018.

April 1, 2018
The DOL has proposed delaying the final rule by 90 days, until April 1, 2018.

Provided By:
Touchstone Consulting Group

OVERVIEW

On Dec. 16, 2016, the Department of Labor (DOL) released a final rule to strengthen the claims and appeals requirements for plans that provide disability benefits and are subject to the Employee Retirement Income Security Act (ERISA). The final rule is currently scheduled to apply to claims that are filed on or after Jan. 1, 2018. However, on Oct. 12, 2017, the DOL **proposed to delay the final rule for 90 days—until April 1, 2018**.

According to the DOL, concerns have been raised that the final rule will impair workers' access to disability benefits by driving up costs and increasing litigation. During the delay, the DOL will review the final rule to determine whether it is unnecessary, ineffective or imposes costs that exceed its benefits, consistent with President Donald Trump's executive order on reducing regulatory burdens.

ACTION STEPS

Sponsors of ERISA plans that include disability benefits should continue to monitor the status of the final rule. If the new requirements take effect, entities that administer disability claims will be required to provide new procedural protections to disability claimants.

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ERISA Requirements

Section 503 of ERISA 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
- ✓ Afford a reasonable opportunity to any participant whose claim for benefits has been denied for a **full and fair review** by the appropriate named fiduciary of the decision denying the claim.

The DOL has proposed a 90-day delay to examine the impact of the final rule. When its review is complete, the DOL may allow the final rule to take effect, propose another extension, withdraw the final rule or propose amendments to it.

The DOL first adopted claims procedure regulations for employee benefit plans in 1977. In 2000, the DOL updated its claims procedure regulations by improving and strengthening the minimum requirements for employee benefit plans, including plans that provide disability benefits. Effective for plan years beginning on or after Sept. 23, 2010, the Affordable Care Act (ACA) amended ERISA to include enhanced internal claims and appeals requirements for group health plans.

Additional Protections for Disability Claimants

The final rule requires that plans, plan fiduciaries and insurance providers comply with additional procedural protections when dealing with disability benefit claimants. The final rule includes the following requirements for the processing of claims and appeals for disability benefits:

- ✓ ***Improvement to Basic Disclosure Requirements***: Benefit denial notices must contain a more complete discussion of why the plan denied a claim and the standards used in making the decision.
- ✓ ***Right to Claim File and Internal Protocols***: Benefit denial notices must include a statement that the claimant is entitled to receive, upon request, the entire claim file and other relevant documents. Benefit denial notices also have to include the internal rules, guidelines, protocols, standards or other similar criteria of the plan that were used in denying a claim or a statement that none were used.
- ✓ ***Right to Review and Respond to New Information Before Final Decision***: The final rule prohibits plans from denying benefits on appeal based on new or additional evidence or rationales that were not

What is a disability benefit? A benefit is considered a "disability benefit" if the claimant has to be disabled in order to obtain the benefit. It does not matter how the benefit is characterized or whether the plan as a whole is a retirement plan or a welfare plan. If the claims adjudicator must **make a determination of disability** in order to decide a claim, the claim must be treated as a disability claim for purposes of the DOL's claims procedures.

included when the benefit was denied at the claims stage, unless the claimant is given notice and a fair opportunity to respond.

- ***Avoiding Conflicts of Interest***: Plans must ensure that 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. For example, a claims adjudicator or medical or vocational expert could not be hired, promoted, terminated or compensated based on the likelihood of the person denying benefit claims.

- ***Deemed Exhaustion of Claims and Appeal Processes***: If plans do not adhere to all claims processing rules, the claimant is deemed to have exhausted the administrative remedies available under the plan, unless the violation was the result of a minor error and other specified conditions are met. If the claimant is deemed to have exhausted the administrative remedies available under the plan, the claim or appeal is deemed denied on review without the exercise of discretion by a fiduciary and the claimant may immediately pursue his or her claim in court.

- ***Certain Coverage Rescissions Are Adverse Benefit Determinations Subject to the Claims Procedure Protections***: Rescissions of coverage, including retroactive terminations due to alleged misrepresentation of fact (for example, errors in the application for coverage), must be treated as adverse benefit determinations that trigger the plan's appeals procedures. Rescissions for nonpayment of premiums are not covered by this provision.

- ***Notices Written in a Culturally and Linguistically Appropriate Manner***: Similar to the ACA standard for group health plan notices, the final rule requires that benefit denial notices be provided in a culturally and linguistically appropriate manner in certain situations.

Proposed Delay

On Oct. 10, 2017, the DOL issued a proposed rule that would delay the applicability of the final rule by 90 days—until April 1, 2018. According to the DOL, after the final rule was published, concerns were raised that its new requirements will impair workers' access to these benefits by driving up costs.

The DOL concluded that, consistent with President Trump's policy on alleviating unnecessary regulatory burdens, it is appropriate to give the public an additional opportunity to submit comments on the potential impact of the final rule. The DOL stated that it will review these comments as part of its effort to examine regulatory alternatives. Based on its review, the DOL may decide to allow all or part of the final rule to take effect as written, propose a further extension, withdraw the final rule or propose amendments to the final rule.

Source: DOL's Employee Benefit Security Administration (EBSA)