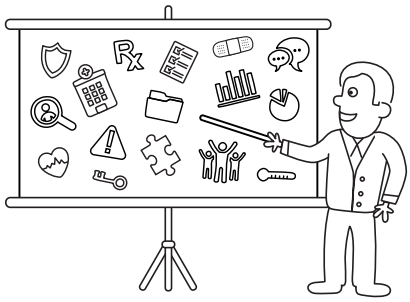
A Game Changer: New ERISA Disability Claims Handling Rules



After years of litigation flowing from disability benefits denials, the U.S. Department of Labor issued a **Final Rule** in late 2016 amending the regulations governing claims handling procedures for ERISA disability claims. The new rules will apply to claims filed on or after April 1, 2018.

Section 503 of the Employee Retirement Income Security Act (ERISA) has always required every employee benefit plan to:

- Provide notice in writing in understandable language explaining the specific reasons for the denial of a claim, and
- Provide an individual with an opportunity for a full and fair review of the denial.

The Final Rule now specifies in great detail how disability plans are to meet these requirements.

What are Matrix and Reliance Standard doing to comply with the new regulations?

Not to worry – our disability claims handling procedures will embrace the new rules and will continue to be best in class!

We will be ready to administer our clients' disability plans in compliance with the new regulations by April 1, 2018. Much of what's outlined here is a best practice for Matrix and Reliance Standard, but we're taking the necessary steps to ensure compliance. We have assembled a task force of experts in disability plans, claims handling procedures, ERISA, and customer service. We are undertaking the following actions to be in compliance with the new rules before April 1, 2018:

- Updating our standard disability plans for changes required by the new rules.
- Reviewing our current claims handling procedures.
- Polishing our written internal claims handling guidelines to be compliant and ready for inclusion in denial notices.
- Revamping our denial letter templates to ensure inclusion of all the new required disclosures. Many of these were previously "best practices" but we will make certain our letters are fully compliant.
- Providing extensive retraining to our claims examiners and appeals staff.
- Engaging language service providers to translate notices into applicable non-English languages and handle calls for claimants.

Key changes at a glance

1. Independence and impartiality of claims adjudicators.

Persons involved in making claims decisions initially or on appeal must be independent and impartial. This includes claims adjudicators, medical professionals rendering disability opinions and others able to influence the outcome. For example, employment or decisions regarding compensation, promotion or similar matters cannot be made based upon the likelihood (or in an attempt to influence) that an individual will support the denial of disability benefits. Many of these changes are already incorporated into our best practices.

2. Improvements to disclosure requirements.

Benefit denial notices must contain:

- A complete discussion of why the plan denied the claim and the standards applied in reaching the decision.
- The basis for disagreeing with the views of health care or vocational professionals whose opinions were provided by the claimant or obtained at the behest of the plan, regardless of whether they were relied upon in making the claim determination.
- The basis for disagreeing with a finding of "disability" by the Social Security Administration (SSA), if applicable.
- The specific internal rules, guidelines, protocols, standards or other similar criteria the plan relied upon in making the adverse determination or a statement that such guidelines, etc. do not exist.
- If the denial is based on a medical necessity, experimental treatment or similar exclusion, an explanation of the scientific or clinical judgment for the determination or a statement that such will be provided free of charge upon request.

3. **Claimant's right to access entire claim file.** A claimant must be given timely notice of his or her right to access to the entire claim file and relevant documents, and be provided the right to present evidence in support of his or her claim during the review process. For this reason, an initial adverse benefit determination must contain a statement that the claimant is entitled to receive, upon request and without charge, the documents relevant to the claim for benefits. Currently, this is only required in notices of adverse benefits determinations on appeal.

4. **Notice of new or additional evidence or rationale before adjudication.** If the plan will rely upon new evidence or rationale to support its denial on appeal, the plan must provide such information to the claimant as soon as possible, and sufficiently in advance of the date on which the notice of adverse benefit determination on review is due. The goal is to give the claimant a reasonable opportunity to address the new evidence prior to the plan's determination on appeal. The notice of new evidence, the claimant's opportunity to respond and the plan's determination must all be accomplished within the existing time frame for an appeal determination (45 days from the filing of the appeal, with a possible 45-day extension).

5. **Claim is denied if a plan fails to comply with claims procedure requirements.** If a plan fails to comply with the ERISA claims procedure requirements, a claimant may seek court review on the basis that the plan failed to provide a reasonable claims procedure which would yield a decision on the merits of the claim. In such case the plan cannot assert a claimant's failure to exhaust administrative remedies; i.e., the plan cannot argue that the claimant has not followed all steps required by the plan prior to filing a lawsuit. The new regulations provide an exception to this rule only when the violation was *de minimus* (small, minor or insignificant) and certain other criteria apply, including no harm to the claimant and the plan was acting in good faith.

6. **Expanded definition of "adverse benefit determination" that triggers appeals procedures.** The current ERISA regulations expand the term ''adverse benefit determination'' to include any denial, reduction or termination of, or a failure to make full or partial payment for a benefit. Rescissions of coverage (other than for the claimant's nonpayment of premiums) including retroactive terminations due to alleged misrepresentation of fact (e.g., errors in the application for coverage) must be treated as adverse benefit determinations, thereby triggering the plan's appeals procedures.

7. **Notices and denials must be written in a "culturally and linguistically appropriate" manner.** If a disability claimant's address is in a county where 10 percent or more of the population is literate only in the same non-English language, benefit denial notices must include a prominent statement in the non-English language about the availability of language services. Such services must include assistance with filing claims and appeals in the non-English language. The plan must provide written notices in the non-English language upon request.

Matrix and Reliance Standard will stay in close contact with the Department of Labor and monitor its website for additional guidance on these new ERISA rules.

Next steps?

Our practice leaders and account managers will be in touch with clients to discuss changes to plan notifications, procedures, and more. To learn more, contact your Account Manager and check out the blog at Matrix-Radar.com for real-time updates.

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