TIC International Corporation
Benefit Administrators and Consultants

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CLIENT BULLETIN

DOL Publishes Final Regulation Concerning Disability Claims and Appeals Procedures

The Department of Labor published a *Final Rule* governing claims procedures for plans providing disability benefits. The final rule revises and strengthens the current rules primarily by adopting certain procedural protections and safeguards for disability benefit claims that are currently applicable to claims for group health benefits pursuant to the *Affordable Care Act.* A *Fact Sheet* was also published.

The new regulation (including the contractual limitation expiration date as explained on page 4) applies to all claims for *disability* benefits filed on or after January 1, 2018.

Before taking a look at the major changes in the disability claims regulations, we will review the criteria for determining whether a benefit is a "disability benefit." Footnote 2 to the final regulations explained:

> A *benefit is a disability benefit*, subject to the special rules for disability claims under the Section 503 Regulation, if the *plan conditions its availability to the claimant upon a showing of disability*. 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 Section 503 Regulation, and it does not matter *how the benefit is characterized by the plan or whether the plan* as a whole *is a pension plan or a welfare plan*.
>
> On the other hand, when a plan, including a pension plan, provides a benefit the availability of which is conditioned on a *finding of disability made by a party other than the plan*, (*e.g.,* the Social Security Administration or the employer's long-term disability plan), then a claim for such benefits is not treated as a disability claim for purposes of the Section 503 Regulation. *See* FAQs About The Benefit Claims Procedure Regulation, A–9 (*https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/programs-and-initiatives/outreach-and-education/hbec/CAGHDP.pdf*) (emphasis added.)

A redline version of the DOL claims regulations showing the changes made by the Final Rule is available by "*clicking here*."

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According to the *Preamble*, the major provisions in the Final Rule concerning disability claims require that:

(1) Claims and appeals must be adjudicated in a manner designed to ensure independence and impartiality of the persons involved in making the benefit determination;

(2) benefit denial notices must contain a complete discussion of why the plan denied the claim and the standards applied in reaching the decision, including the basis for disagreeing with the views of health care professionals, vocational professionals, or with disability benefit determinations by the Social Security Administration (SSA);

(3) claimants must be given timely notice of their right to access their entire claim file and other relevant documents and be guaranteed the right to present evidence and testimony in support of their claim during the review process;

(4) claimants must be given notice and a fair opportunity to respond before denials at the appeals stage are based on new or additional evidence or rationales;

(5) plans cannot prohibit a claimant from seeking court review of a claim denial based on a failure to exhaust administrative remedies under the plan if the plan failed to comply with the claims procedure requirements unless the violation was the result of a minor error;

(6) certain rescissions of coverage are to be treated as adverse benefit determinations triggering the plan's appeals procedures; and

(7) required notices and disclosures issued under the claims procedure regulation must be written in a culturally and linguistically appropriate manner.

A Closer Look At Selected Changes

First, let's take a look at the new notice requirements applicable to an initial denial of claim and then we will look at the new rules applicable to a denial on appeal. Using the redline version is an easy way to quickly skim the changes.

Notice of Initial Denial of Claim

In the case of an initial denial with respect to disability benefits, the Plan must provide a discussion of the decision, including an explanation of the basis for disagreeing with or not following:

- The views presented by the claimant to the plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;
- The views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit

determination, without regard to whether the advice was relied upon in making the benefit determination; and

- A disability determination regarding the claimant presented by the claimant to the plan made by the Social Security Administration;

In addition, if the initial denial is based on a medical necessity or experimental treatment or similar exclusion or limit, the plan must provide:

- either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;
- either the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist; and
- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits.

Further, in the case of an initial denial with respect to disability benefits, the notification must be provided in a culturally and linguistically appropriate manner (the 10% non-English-speakers rule discussed below).

Notice Of Denial On Appeal

In the case of a denial of a claim for disability benefits on appeal, the plan must provide a discussion of the decision, including an explanation of the basis for disagreeing with or not following:

- The views presented by the claimant to the plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;
- The views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's claim denial on appeal, without regard to whether the advice was relied upon in making the benefit determination; and
- A disability determination regarding the claimant presented by the claimant to the plan made by the Social Security Administration.

In addition, if the disability claim denial on appeal is based on a medical necessity or experimental treatment or similar exclusion or limit, the plan must provide:

- either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical

circumstances, or a statement that such explanation will be provided free of change upon request; and

- either the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist.

Further, in the case of a denial on appeal with respect to a claim for disability benefits, the notification of the denial must be provided in a culturally and linguistically appropriate manner (the 10% non-English-speakers rule discussed below).

Finally, the final disability regulation adds a new requirement that is technically applicable only to disability claim denials on appeal. The requirement states that the statement of the claimant's right to bring an action under Section 502(a) of ERIISA shall also describe any applicable contractual limitations period that applies to the claimant's right to bring such an action, *including the **calendar date** on which the contractual limitations period expires for the claim*.

The *Preamble* to the regulations explained that in the DOL's view all claim denials on appeal should contain some explanation of any plan-imposed time limitations in which a claimant can sue. In fact, the DOL said the provision of a calendar date would be appropriate for all plan types. However, under the new regulation, only disability claims denials on appeal are required to comply with the calendar date rule for pan-imposed limitations periods. Numerous courts have held that the disclosure of any plan-imposed limitations periods is already required by the claims regulations, although some have held otherwise. See *Final Rule* at footnote 29. In this age of increased disclosures, it seems like a "best practice" to disclose any plan-imposed limitations.

The "Culturally And Linguistically Appropriate Manner" Standard

In regards to the requirement that notices and disclosures issued under the claims procedure regulation must be written in a culturally and linguistically appropriate manner, the final rule adopts the standards already applicable to group health plans under the *ACA Claims and Appeals Final Rule*.

Under that rule, if a claimant's address is in a county where 10% or more of the population residing in that county are literate only in the same non-English language as determined in guidance based on American Community Survey data, notices of adverse benefit determinations to the claimant would have to *include a statement prominently displayed in the applicable non-English language clearly indicating how to access language services provided by the plan*. In addition, plans must provide a customer assistance process (such as a telephone hotline) with oral language services in the non-English language and provide written notices in the non-English language upon request.

Each year the U.S. Census Bureau publishes a list of counties that meet the 10% threshold. For 2016, the applicable languages are Chinese, Tagalog, Navajo and Spanish.

A complete list of affected counties is available online at:
https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/internal-claims-and-appeals.

Scroll down to the link at:
Culturally and Linguistically Appropriate Services (CLAS) County Data.

That link takes one to the CMS site and, for now, the 2016 Data as listed in:
https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/CLAS-County-Data_Jan-2016-update-FINAL.pdf.

This list will be updated annually following the release of the applicable ACS data. If the general timing of the release of the data does not change in future years, CMS anticipates releasing this list in December or the following January of each year.

Transition Rule Applicable For Disability Claims Filed Between January 18, 2017 and December 31, 2017

The Final Rule requires the following be included in any *initial notice of denial* and *notice of denial on appeal* ("denial") for disability claims filed between January 18, 2017 and December 31, 2017, as applicable:

- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the denial and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request; and

- If the denial determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

These transitional requirements are continued in the regulations effective for disability claims filed on or after January 1, 2018.

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