NAVIGATING ERISA REGULATIONS FOR DISABILITY CLAIMS

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Executive Summary *In the US, effective April 1, 2018, the US Department of Labor (DOL) passed updated regulations for employer-sponsored benefit plans subject to ERISA (the Employee Retirement Income Security Act of 1974 that established federal law to set minimum standards for most voluntarily established pension and health plans in private industry to provide protection for individuals in these plans)[1]. Benefit plan administrators for group disability and in some cases voluntary policies were tasked with achieving compliance with the regulations by this date. The regulations are comprehensive and cover several aspects of the claim process. While most companies have crossed initial implementation and training off their list, taking the time to review these areas periodically to ensure nothing has been overlooked or misinterpreted could help identify and mitigate potential gaps in compliance.*

Introduction

Over the past year, those in the US have likely heard about the new ERISA regulations applicable to disability claims. The final regulation passed by the US Department of Labor (DOL) impacts claims submitted on or after April 1, applies to group and some voluntary disability plans, and amends current claim procedure regulations for disability benefits (US Department of Labor, 2016). Several important changes to claim procedures are required, with the purpose of providing consumers additional procedural protections.

For those responsible for complying with new regulations, ensuring that none have been overlooked or misinterpreted means working with those familiar with the law. At SALT we often hear from those seeking expertise and support for their disability claim administration, including areas that require additional training. To address questions related to the latest ERISA regulations, we recently collaborated with Brooks Magratten, a partner at Pierce Atwood LLP with extensive experience defending insurers and plan fiduciaries in ERISA litigation. The below represents some of the areas that may be overlooked despite insurers' best efforts to comply.

First the Basics - Which Plans Are Subject to ERISA?

For those unfamiliar with the nuances of different benefit plans, an ERISA plan can be any employee benefit plan sponsored or maintained by a private-sector employer or employee organization. These include health, disability, life insurance and pension plans.

However there are certain employer-sponsored plans excluded from ERISA. These are:

- *Public institution plans*. For example, plans sponsored or maintained by public schools and state, county or municipal governments are exempted from ERISA.

- *Church plans*. Exactly what constitutes a "church plan" can be a factually intensive inquiry. This determination often depends on how closely an employee benefit plan is affiliated with a religious organization.

In addition, there are plans that may qualify under ERISA that may appear exempt. These are:

- *Union plans*. Unions are generally considered to be private employee organizations, even if their members are public employees. A plan sponsored by a private union may be subject to ERISA.

- *Individual policies*. Many people equate group plans with ERISA and believe individual poli-

cies are not subject to ERISA. This is not always true. There are circumstances in which individual insurance policies can be part of an ERISA plan, especially where there has been significant employer involvement in procuring coverage.

What Are the Key Considerations for Compliance?
There are five key areas plan administrators should have addressed with the implementation of the DOL rule. All of these serve to provide more transparency regarding the decision and appeal process. However, what varies among these is the level of subjectivity that can be applied by those responsible for meeting compliance standards ongoing. This is where the proper level of training and experience is critical to ensuring your organization isn't left exposed.

- *Promotion of Impartial Decision-Making*
  When it comes to who is making claim decisions, additional steps should be taken to ensure impartiality. Claim administrators should not rely extensively on one or a select few vendors for example. Recruiting a broad base of vendor resources puts the administrator in a better compliance light.

  Also, vendors selected to handle decisions on the part of the insurer should be monitored closely as courts are now permitting discovery on these relationships. Periodically auditing vendor quality, watching court decisions that implicate vendors, and ensuring vendor contracts are updated to comply with ERISA regulations are all important.

  Finally, new DOL regulations require insurers to vet their vendor contracts carefully to remove any provision that might cause biased claim reviews. Hiring, compensation, termination and promotion of responsible parties must not be based on the likelihood of a claim denial.

- *Greater Details in Denial and Uphold Letters*
  Communication about the basis of denials - or the upholding of these decisions - should be clear and supported. These letters must include an explanation of the basis for any disagreement with treating physicians and vocational consultants, views of experts retained by the administrator, and Social Security Administration determinations.

  Letters must include 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.

  In this respect Claim Administrators should consider providing extensive and frequent training to claim staff about how to communicate with claimants in a way that will satisfy new regulatory requirements.

- *More Discernment Around Soliciting Reviews and Timely Notice of New Evidence*
  The new regulations may cause Claim Analysts to reflect on the need for soliciting additional reviews. Simply because a claimant provides new documentation to a plan does not mean that the plan has been provided with new information. Claim fiduciaries should scrutinize new claim documentation before deciding whether to seek further expert review. This is key to avoid the unnecessary risk of not meeting required appeal process deadlines.

  If an administrative review of a claim is conducted and produces new evidence, it must be provided to the claimant "as soon as possible, sufficiently in advance of" the review completion deadline. The back-and-forth between Claim Analysts and claimants can push the claim administration process up against hard deadlines. Claim Analysts and claimants can agree to extend deadlines, but that needs to be clearly communicated to the claimant.

- *Plan Limitations Periods*
  Uphold letters must describe any applicable contractual limitations period including the calendar date on which the contractual limitations period expires for the claim. A limitations period for legal actions is typically capped at 3 years from the time of written proof of loss, which must be sent within 90 days, or no later than 1 year if the typical period is not considered reasonably possible. Insurers may be wise to seek legal advice on limitations periods, especially given variations that exist between states.

- *Culturally and Linguistically Appropriate Notices*
  The ZIP code the claimant resides in is a key detail that should not be overlooked. If he is in a county where 10% or more of the inhabitants are literate only in the same non-English language, then the Administrator must provide information (orally and written) in that particular non-English language. Many administrators now routinely include notices in Spanish and Chinese with instructions for obtaining translation services.

Identifying Knowledge and Process Gaps in Meeting Compliance

Many insurers will have spent a considerable amount of time implementing the changes noted above. However, given the significant potential for inadequately meeting the standards or misconstruing what's required, insurers should consider partnering with an expert familiar with these regulatory requirements to offer ongoing training to address items such as treatment records, Social Security findings and expert reports.

The new regulations require claim staff to exercise discretion about when to submit new medical information for further expert review. For example, are you confident that the explanation and level of analysis employed in your uphold letters are acceptable? Are treatment notes being properly analyzed for what qualifies as new information? Working with an expert who can guide you through this process and make you aware of areas needing improvement can be critical to achieving compliance.

Conclusion

Making the time to go beyond just implementing the required changes can be critical to improving your company's processes concerning ERISA requirements. We encourage you to revisit what your claim operation has been doing and seek assistance where necessary in order to meet these important regulatory updates on an ongoing basis.

Notes

1 "U.S. Department of Labor announces decision on April 1, 2018, applicability of final rule amending claims procedure for disability benefit plans," U.S. Department of Labor, January 5, 2018.

About the Authors

Jennifer Daigle is the Vice President of Operations at SALT Associates, an RGAX company and provider of Disability and Life claims management solutions based outside Portland, ME. She has over 30 years of insurance experience having worked for industry leaders in both the direct as well as on the reinsurance side of the business. At SALT Jennifer leverages her broad risk management background gained in various claims and underwriting leadership roles, as well as her extensive knowledge of Group and Individual Disability and Life insurance products, to assist clients seeking expertise and support in their claim operations.

Brooks Magratten is the partner in charge of the Pierce Atwood LLP Providence office. He has more than 30 years of experience in insurance and ERISA litigation. He is the former Northeast Regional Director of DRI and former chair of its Life, Health & Disability Insurance Committee. Brooks is a frequent author, instructor and lecturer on ERISA issues and trial skills. He has represented commercial interests in litigation throughout the northeastern US. He has been an adjunct professor of the Roger Williams Law School, teaching federal practice and procedure.

From the September 2018 Annual Meeting of the Academy of Life Underwriting (left to right): Jodi McDonald, Hannover Life; Sharon Garner, American National; Jennifer Dahl, RBC Insurance.