ERISA Regulations FAQ

April 1, 2018 Revisions

The Department of Labor recently issued new disability claim regulations under ERISA governed disability plans.

Which Policyholders/Plans Are Impacted?

ERISA applies to private employer-provided employee welfare benefit plans. It does not apply to plans sponsored by governmental agencies or church-based plans.

What Products Are Impacted?

The regulations apply to claims for "disability benefits." The regulation describes disability benefit as follows:

- 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 on 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.

For The Standard, this means that fully-insured Short-Term Disability (STD), Long-term Disability (LTD), Individual Disability Guaranteed Standard Issue (IDI GSI), and Life Waiver of Premium claims are subject to the regulations.

When Do The Regulations Take Effect?

The Regulations apply to claims for disability benefits filed on or after April 1, 2018.

What Has Changed and How Does It Impact The Standard?

The following is a list of the revisions including a short description and the specific impact to The Standard.

1. Ensure independence and impartiality – avoiding conflicts of interest.

The new regulations require that decisions regarding hiring, compensation, termination, promotion, or other similar actions related to individuals who make claims decisions (such as claim adjusters or medical or vocational experts) not be made based on the likelihood that those individuals will support the denial of benefits.

Impact to The Standard: The Standard currently has practices in place to ensure the independence of our claim staff. For example, we don't make any employment or compensation decisions based on the likelihood that a person will deny benefits. Additionally, The Standard is implementing some additional business processes to reinforce this independence.

2. Include discussion of disagreement with treating providers, consulting resources, and Social Security determinations in adverse decision letters.

The new regulations expressly require adverse decision letters (i.e., claim closure and denial letters) (both at the initial claim decision and on appeal) to include the basis for disagreeing with:

- the views of the claimant's treating medical or vocational providers;
- the views of medical or vocational resources obtained by the plan during the evaluation of the claim (whether or not the opinion was relied upon);
- and, a disability determination by the Social Security Administration, when presented by the claimant.

Impact on The Standard: The Standard's Benefits areas periodically conduct best practices trainings on adverse decision letter writing, which incorporate some of these requirements. Additionally, our Benefits' teams have already updated their process around Social Security records that align with the new regulations. All claims teams received additional training on these regulatory changes to ensure our customer letters incorporate these new requirements.

3. Include disclosure of internal rules, guidelines, protocols or standards in adverse decision letters.

The regulations require adverse decision letters to include either the specific internal rules, guidelines, protocols, standards or other similar criteria relied upon in making the adverse determination or, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist.

Impact on The Standard: The Standard's Benefits teams are updating their adverse benefit decision letters to disclose internal guidelines when applicable. For claims where those guidelines are not applicable, claim reviewers will include a statement that no internal rule, guideline, protocol, standard or other similar criteria was relied upon in making the claim decision.

4. **Include notice of right to receive relevant documents in adverse decision letters.**

The regulations create a new requirement that the initial adverse decision letter must include 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 his/her claim for benefits.

Impact on The Standard: The right to receive relevant documents is not a new requirement. The Standard currently has a process in place for handling these requests. The Standard did make a change to include the notice in our initial adverse decision letters.

5. **Include culturally and linguistically appropriate notices in adverse decision letters, and right to receive relevant documents.**

Under the regulations adverse decision letters (both at the initial claim level and on appeal) must be provided in a culturally and linguistically appropriate manner. This requirement is triggered when 10 percent of residents in the claimant's area speak the same non-English language. When the 10 percent threshold is met, the regulation requires plans to:

- provide oral language services in the applicable non-English language (including such things as answering questions by phone and assistance with filing claims and appeals);
- provide translated decision notices in the applicable non-English language upon request; and
- to include in English letters, a prominent notice in the applicable non-English language informing claimants of how to access the language services.

Impact on The Standard: The Standard, through our translation vendors, currently provides language services to our claimants upon request. As a result, the only change to The Standard's claim processes is to provide notice of those services in our adverse decision letters. Based on current information from the U.S. Census Bureau, those notices must be translated into Spanish, Navajo, Mandarin and Tagalog. The Standard has updated letters to include those translated notices in adverse benefit decision letters.

6. **Include the contractual limitations period in adverse decision letter on review.**

A new section of the regulations will require adverse decision letters to also include a description of any applicable contractual limitation period applicable to the claimant's right to bring such an action, and the date the contractual limitation expires.

Impact on The Standard: The Standard's current group disability policies include a Time Limits on Legal Actions provision that does limit the period for bringing legal action for claims under the policy (typically three years). For ease of administration, The Standard's appeal unit will incorporate this new language into their adverse decision letters.

7. **Coverage rescissions added to definition of adverse benefit determination.**

The regulations now adds coverage rescissions to the definition of adverse benefit determination.

Impact on The Standard: This change does not impact The Standard's current processes around rescissions.

8. **Full and fair review requires right to review and respond to new information or rationale before adverse decision on review.**

The regulations implement a new requirement that claimants be provided a chance to review and respond to any new or additional evidence considered, relied upon, or generated during the appeal process, and any new or additional rationale supporting the adverse claim decision.

The evidence or rationale must be provided "as soon as possible and sufficiently in advance" of the deadline for completing the review to give the claimant a reasonable opportunity to respond. However, the current timeframes to

complete a review (45 days after submission, with an additional 45 days for special circumstances) were not extended by the new regulations.

Impact on The Standard: This is the most significant impact because it requires an additional process to fit within existing timeframes. The Standard's appeal unit has:

- adopted several process improvements to reduce turnaround times for completing reviews.
- created new letter templates and processes designed to facilitate conducting this new open dialogue process.

9. Administrative remedies deemed exhausted for procedural violations - strict compliance.

As adopted, the new regulations require strict compliance with ERISA's procedural regulations. Where the plan fails to strictly comply, the claimant will be deemed to have exhausted administrative remedies and could proceed to litigation.

There are, however, some limited exceptions to this, including failures that are:

- de minimis (i.e., minor) and non-prejudicial;
- attributable to good cause or matters beyond the plan's control;
- in the context of an ongoing good-faith exchange of information; and
- not reflective of a pattern or practice of non-compliance.

Impact on The Standard: This does not have a direct action requirement other than reinforcing the importance of ensuring our claims practices are consistent with the new regulations.