



Disability Claims Procedure Rules Changed to Require Plan Updates

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Disability Claims Procedure Rules Changed to Require Plan Updates

In the midst of the holiday season, the Department of Labor (DOL) quietly released final regulations modifying the claims procedures for ERISA plans that provide disability benefits. At first blush, the modified rules appear to only impact disability benefit plans; however, other ERISA plans providing disability benefits, including non-qualified deferred compensation arrangements, may also be subject to these regulatory changes. In response, ERISA plan sponsors will need to review claim procedure language to determine whether updates are required. Such language may be present in the plan document, summary plan descriptions, or as standalone documents.

There are two effective dates relevant under these regulations.

January 18, 2017: The technical effective date of the regulations is January 18, 2017. Minor regulatory changes (identified below) apply to disability claims filed during a transition period beginning after the January 18, 2017 effective date and extending through December 31, 2017.

January 1, 2018: The remaining changes implemented under the regulation apply beginning January 1, 2018.

More detail about the changes required in each time period is included below:

Transition Period: 2017 Changes

For claims filed between January 18 and December 31, 2017, the DOL is imposing the following additional standards (as applicable) on denial notices to ensure a full and fair review has occurred.

- The notice either needs to provide (i) the specific rule, guideline, etc., that was relied upon in making the adverse determination relied; or (ii) a statement that that such a rule was relied upon and notice that a copy will be provided for free upon request. (Note: this standard will continue to apply in 2018; however, at that time, the denial notice must also state the negative, i.e., if the plan did not rely on a rule, guideline, etc., it must so state.)
- If the claim is denied based upon medical necessity, experimental treatment, or a similar exclusion or limit, the notice must provide (i) an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical situation; or (ii) a statement that the explanation will be provided for free upon request. (Note: this standard will continue to apply in 2018.)

Full Implementation: 2018 Changes

- **Independent and Impartial Review of Claims.** The regulations add additional protections to ensure that the individual who decides a claim does not have a conflict of interest or incentive to do so. To that end, the regulations add language that a plan's decisions regarding the hiring, compensation, termination, promotion, etc. of the decision maker (including third-party decision makers) cannot be made based upon the likelihood that the decision maker will support the denial of a disability benefit claim. This language was added to mirror an Affordable Care Act regulation standard.

- **Notices to be Culturally and Linguistically Appropriate.** Adverse benefit determinations must be written in a culturally and linguistically appropriate manner. For this purpose, if at least 10% of the workforce has a predominant language other than English, the plan must provide:
 - Oral language services (e.g., a hotline) that include answering questions assisting with filing claims and appeals in the non-English language;
 - Notices must be provided, on request, in that language; and
 - English language versions must include a statement “prominently displayed” in the applicable non-English language indicating how to access the oral language services.
- **Improvement to Disclosures.** Benefit denial notices will be required to contain a more complete discussion of the basis for the denial and the standards applied. In addition to the requirements referenced in the “Transition Period” section above, benefit denial notices will need to include:
 - A discussion of the basis for disagreeing with health care professionals and vocational professionals, including information received but not relied upon
 - A discussion of the basis for disagreeing with a disability benefit determination made by the Social Security Administration
 - An adverse benefit determination at the initial claims stage must include a statement that the claimant is entitled to receive, upon request, documents relevant to the claim for benefits.
- **Right to Review and Respond to New Information before a Final Decision is Made.** Plans must provide claimants, free of charge, with

new or additional evidence considered, relied upon, or generated by the plan, insurer, or other person making the benefit determination during the pendency of the appeal in connection with the claim. The claimant must then be given a reasonable opportunity to respond to the evidence or rationale before a decision is announced. Deadline extensions may be required to meet the reasonableness standard, although the regulations do not expressly require such extensions. **Note that this right to review and respond only applies at the appeal stage.**

- **Deemed Exhaustion of ERISA Administrative Remedies.** The regulations provide that if a plan fails to adhere to all the requirements in its claims procedure regulation, the claimant is deemed to have exhausted administrative remedies and can proceed to enforce rights in court. Limited exceptions apply to this rule.
- **Coverage Rescission is an Adverse Benefit Determination.** The regulations amend the definition of an adverse benefit determination to include a rescission of disability benefit coverage that has a retroactive effect, except to the extent that the rescission is based upon a failure to timely pay required premiums or contributions toward the cost of coverage.

Any party responsible for or involved with making determinations with respect to disability benefit claims, including plan sponsors, will need to digest and implement the various nuances of the final regulations and fully implement new procedures before the January 1, 2018. Attention to the totality of the required changes now is recommended to implement a seamless compliance strategy across all impacted plans.

