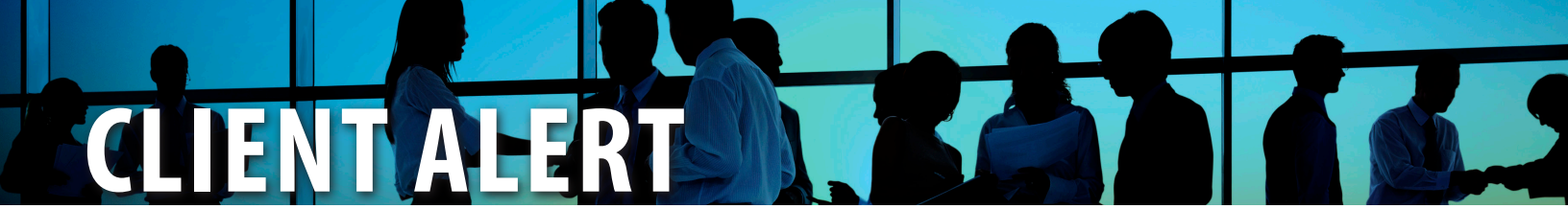

EMPLOYEE BENEFITS

FINAL ERISA CLAIMS PROCEDURES FOR PLANS PROVIDING DISABILITY BENEFITS EFFECTIVE APRIL 1, 2018

by Cynthia A. Moore and Eric W. Gregory

March and April will be critical months for employers who sponsor ERISA-governed employee benefit plans that provide benefits subject to the disability claim procedures. Any claims filed after April 1, 2018 will be subject to a new final rule issued by the Department of Labor ("DOL") in December of 2016. Plans subject to these rules will include health and welfare plans, qualified retirement plans, and even nonqualified deferred compensation plans. The new rules are intended to ensure the impartiality of plan decision-makers, and will require additional disclosures to plan participants.

Types of Plans Affected

Generally, the new rules apply to all plans subject to the Employee Retirement Income Security Act of 1974 ("ERISA"). Any plan (not just a "disability" plan) that requires a plan's claims adjudicator to make a determination of disability in order to decide a claim is subject to the new regulations. Therefore, employers should review plans that provide for benefits, accelerated vesting or waiver of allocation of accrual requirements on account of disability.

Qualified Retirement Plans

Retirement plans may need to be updated if the plan administrator makes the determination of disability. If, however, the determination is made by a third party (such as an LTD insurer or the Social Security Administration), the claims procedures may not need to be updated. See, Q&A 9 of https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/benefit-claims-procedure-regulation.

Nonqualified Plans

Even though nonqualified deferred compensation plans are exempt from much of ERISA, they are subject to ERISA's claims regulation provisions. Therefore, these plans are also covered by the new rule if the plan administrator makes disability determinations under the plan.

Welfare Plans

Most ERISA-covered disability plans are insured, so in most cases, it will be the disability carrier's responsibility to revise its ERISA claim procedures. The plan administrator/employer should follow up with the STD/LTD insurers to make sure that certificates of coverage will be updated to reflect the new claims procedures before April 1, 2018.

A self-insured short-term disability plan that qualifies as a "payroll practice" may not need to be revised as it is exempt from ERISA. However, the claims administrator may consider adopting some or all of the provisions of the final rule as a best practice.

Additionally, summary plan descriptions ("SPDs") and wrap plans should be updated and distributed to participants.

Major Changes in the New Rule

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.* Similar to the Affordable Care Act rules that apply to group health plans, decisions regarding hiring, compensation, termination, promotion or similar matters with respect to a claims adjudicator or other expert must not be made based on the likelihood that the person will support the denial of benefits.

2. *Improved disclosure requirements*.

   (a) Any claim denial (at the initial denial stage or on appeal) must include a discussion of the decision, including an explanation of the basis for disagreeing with:
   the treating physician or vocational expert who evaluated the claimant;
   the views of the medical or vocational expert obtained by the plan; and
   a disability determination by the Social Security Administration presented by the claimant to the plan.
   (b) The denial notice must include the internal rules, guidelines, protocols, standards or other similar criteria of the plan that were relied on in denying the claim (or a statement that such criteria does not exist).
   (c) A statement that the claimant is entitled to receive, upon request, relevant documents.

3. *Right to review and respond to new information before final decision*. In order to provide a full and fair review, the plan must provide the claimant with any new or additional rationale or evidence relied on by the plan in making the benefit decision. The new or additional rationale or evidence must be given to the claimant as soon as possible and sufficiently in advance of the date the claim decision is to be made to give the claimant a reasonable opportunity to respond. This will give the claimant the chance to present his or her case at the administrative appeal level, rather than after the claim denial has been issued.

4. *Deemed exhaustion of claim and appeal procedures*. If a plan fails to adhere to all of the requirements in the claim procedures regulation, the claimant would be deemed to have exhausted his or her administrative remedies and would be able to file a lawsuit against the plan. However, the plan is still in compliance if the violation was:

   - de minimis;
   - 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.

5. *Coverage rescission is an adverse benefit determination.* A rescission of disability benefit coverage that has a retroactive effect is an adverse benefit determination and may be appealed. Terminating coverage due to a failure to pay premiums is not a rescission of coverage.

6. *Notices must be provided in a culturally and linguistically appropriate manner.* Similar to the ACA rules that apply to group health plans, if the claimant's address is in a county where 10% or more of the county's population are non-English literate, any claim denial notice must include a statement, in the applicable non-English language, clearly indicating how to access the plan's language services.

7. *Disclosure of contractual limitations period.* If the plan has a limited period of time in which a claimant can file a lawsuit against the plan, a denial notice on appeal must include a description of the contractual limitations period and its expiration date. For example, if a State's statute of limitations for filing a lawsuit is 6 years but the plan has a contractual limitations period of 3 years beginning on the date the claim is denied on appeal, the denial notice must describe the 3-year period and state the expiration date. It would also be a best practice to include this information in denial notices for other types of plans, such as group health plans.

Conclusion

Employers should be sure to review the new rules, review their plans to determine whether the rules apply, and prepare updated SPDs to comply with the disclosure requirements.

Please contact the authors of this Alert or any member of the Dickinson Wright employee benefits practice team if you have any questions about the disability claims rules, need assistance in developing appropriate claims language, or in reviewing insurance carrier documents.

This client alert is published by Dickinson Wright PLLC to inform our clients and friends of important developments in the field of employee benefits law. The foregoing content is informational only and does not constitute legal or professional advice. We encourage you to consult a Dickinson Wright attorney if you have specific questions relating to any of the topics covered.

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