Patterson Belknap Webb & Tyler LLP

Employee Benefits & Executive Compensation Alert February 2018

Prepare for New Claims Procedures for Disability Benefit Plans

After several rounds of additional review and a three-month delay in the effective date, the final regulations originally issued by the U.S. Department of Labor (the "DOL") in December 2016, which established new requirements for processing disability claims under employee benefit plans (the "Disability Claims Regulations," which are available here), will finally take effect on April 1, 2018. These new regulations add requirements similar to those that apply to claims involving group health plans under the Affordable Care Act rules. Plan sponsors and plan administrators handling disability benefit claims should carefully review the new procedural requirements to ensure compliance in connection with the issuance of adverse disability benefit determinations.

Disability Benefit Plans Covered

The Disability Claims Regulations apply to benefit plans in which (a) the availability of a benefit is based on a showing that the participant has a disability ***and*** (b) the determination of the participant's disability is made by the plan administrator (or its delegate or agent). Common examples of such disability benefit plans may include (i) health and welfare plans, such as short term disability and long term disability plans, (ii) qualified retirement plans and 403(b) plans where disability affects the vesting, timing, or calculation of a participant's benefits, and (iii) certain non-qualified deferred compensation plans that provide for benefits or vesting in the event of a disability. However, according to guidance provided by the DOL, "if a plan provides a benefit the availability of which is conditioned on a finding of disability, and that finding is made by a party other than the plan for purposes other than making a benefit determination under the plan, then the special rules for disability claims need not be applied to a claim for such benefits."[1]

New Requirements in Claims Procedures

Below is a brief summary of certain key changes in the Disability Claims Regulations. All employee benefit plans providing disability benefits for which the Disability Claims Regulations apply should administer disability claims in accordance with these new requirements beginning April 1, 2018.

- **Avoiding Conflicts of Interest.** Plans providing disability benefits must ensure that the claims are adjudicated in a manner designed to ensure independence and impartiality of the persons involved in making the decision. In addition, the hiring, compensation, termination, promotion and similar employment decisions with respect to evaluating professionals (such as claims adjudicators or medical or vocational experts) must not be based on the likelihood that the individual will support the denial of disability benefits.

- **Additional Disclosure Requirements.** In connection with any adverse determination of a disability claim (whether an initial denial or a denial on appeal), a plan must provide a more detailed discussion of the decision, including (i) explaining the basis for disagreeing with any disability determination by the social security administration or a treating physician or vocational professional, (ii) if the adverse determination is based on a medical necessity or experimental treatment or similar exclusion, either an explanation of the scientific or

1 "For example, if a pension plan provides that pension benefits shall be paid to a person who has been determined to be disabled by the Social Security Administration or under the employer's long term disability plan, a claim for pension benefits based on the prior determination that the claimant is disabled would be subject to the regulation's procedural rules for pension claims, not disability claims." U.S. Department of Labor Employee Benefits Security Administration, *Benefit Claims Procedure Regulation FAQs*, https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/benefit-claims-procedure-regulation (last visited February 27, 2018).

clinical judgment for the determination or a statement that such an explanation will be provided upon request, (iii) the specific internal rules, guidelines, protocols, standards, or other similar criteria that the plan relied on in denying the claim (or a statement that those do not exist), and (iv) a statement that the claimant is entitled to receive, upon request, documents relevant to the claim. In addition, in the case of a benefit denial on appeal, the plan must provide a description of any contractual limitations period imposed by the plan (and the resulting deadline) that applies to the participant's right to bring a civil action.

- **Right to Review and Respond to New Information.** A plan must give the participant the right to review and respond to any new or additional evidence or rationale considered, relied upon, or generated by the plan during the pendency of an appeal. This information must be automatically provided to a participant, free of charge, as soon as possible and sufficiently in advance of the date that the plan's decision on appeal is due, in order to give the participant a reasonable opportunity to respond to such new or additional evidence or rationale. The preamble to the regulations indicates that this requirement can apply in a successive manner. If a claimant's response to the evidence provided by a plan causes the plan to generate further reports containing new or additional evidence, then the plan must again provide those materials to the participant as soon as possible and consider any further response from the participant.

- **Deemed Exhaustion of Claims Appeal.** If a plan fails to strictly adhere to the rules for processing disability claims, a claimant will be deemed to have exhausted the plan's administrative procedures and shall be entitled to file a lawsuit, unless the de minimis exception applies (i.e., the failure was de minimis, non-prejudicial, due to matters beyond the plan's control, in the context of on-going good-faith exchange of information, and not reflective of a pattern or practice of non-compliance).

- **Cultural and Linguistic Appropriateness.** If the participant's address is in a county where ten percent or more of the population of that county are literate only in the same non-English language, adverse benefit determinations provided by a plan must include a prominent one-sentence statement about the availability of language services, and upon request, the notice must be provided in the other language. In addition, plans are required to provide oral customer assistance in the non-English language applicable to that county.

Next Steps for Plan Sponsors

Plan sponsors and administrators should review the requirements of the Disability Claims Regulations to determine the potential impact on their disability benefit claims administration and whether any amendments or modifications are necessary to the plan documents, summary plan descriptions, and written administrative procedures, as applicable. Disability claims administration by plans will need to comply with these new regulations effective April 1, 2018.

This alert is for general informational purposes only and should not be construed as specific legal advice. If you would like more information about this alert, please contact one of the following attorneys or call your regular Patterson contact.

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