DOL Announces April 1 Applicability of Final Disability Plan Claims Procedure Regulations

The U.S. Department of Labor (DOL) announced its decision for April 1, 2018, as the applicability date for ERISA-covered employee benefit plans to comply with a final rule (released in December 2016) that imposes additional procedural protections (similar to those that apply to health plans) when dealing with claims for disability benefits. In October 2017, the DOL had announced a 90-day delay of the final rule, which was scheduled to apply to claims for disability benefits under ERISA-covered benefit plans that were filed on or after January 1, 2018.

Effective Date

While the DOL's news release indicates that the DOL has decided on an April 1 applicability date for the final rule, the regulatory provision modified by the 90-day delay specified that the final rule will apply to claims filed "after April 1, 2018."

Plans Subject to the Final Rule

The final rule applies to plans (either welfare or retirement) where the plan conditions the availability of disability benefits to the claimant upon a showing of disability. For example, if a claims adjudicator must make a determination of disability in order to decide a claim, the plan is subject to the final rule. Generally, this would include benefits under a long-term disability plan or a short-term disability plan to the extent that it is governed by ERISA.

However, the following short-term disability benefits are **not** subject to ERISA and, therefore, are not subject to the final rule:

- Short-term disability benefits that are paid pursuant to an employer's payroll practices (i.e., paid out of the employer's general assets on a self-insured basis with no employee contributions); and

- Short-term disability benefits that are paid pursuant to an insurance policy maintained solely to comply with a state-mandated disability law (for example, in California, New Jersey, New York, and Rhode Island).

In addition, if benefits are conditioned on a finding of a disability made by a third-party other than the plan itself (such as the Social Security Administration or insurer/third-party administrator of the employer's long-term disability plan), then a claim for such benefits is not treated as a disability claim and is also **not** subject to the final rule. For example, if a retirement plan's determination of disability is conditioned on the determination of disability under the plan sponsor's long-term disability plan, then the retirement plan is not subject to the final rule (but the final rule would apply to the underlying long-term disability plan).

Overview of the Final Rule

The DOL has published a Fact Sheet that provides an overview of the new requirements, which include the following:

- **New Disclosure Requirements**. New benefit denial notices that include a more complete discussion of why the plan denied a claim and the standards it used in making the decision;

- **Right to Claim File and Internal Protocols.** New statement required in benefit denial notices that regarding claimant's entitlement to receive, upon request, the entire claim file and other relevant documents and inclusion of internal rules, guidelines, protocols, standards, or other similar criteria used in denying a claim (or a statement that none were used).

- **Right to Review and Respond to New Information Before Final Decision.** Plans may not deny benefits on appeal based on new or additional evidence or rationales that were not included when the benefit was denied at the claims stage, unless the claimant is given notice and a fair opportunity to respond.

- **Avoidance of Conflicts of Interest.** Claims and appeals must be adjudicated in a manner designed to ensure independence and impartiality of the persons involved in making the decision. For example, a claims adjudicator or medical or vocational expert cannot be hired, promoted, terminated, or compensated based on the likelihood of such person denying benefit claims.

- **Deemed Exhaustion of Claims and Appeal Procedures.** If a plan does not adhere to all claims processing rules, the claimant is deemed to have exhausted the administrative remedies available under the plan, unless the violation was the result of a minor error and other conditions are met.

- **Certain Coverage Rescissions are Subject to the Claim Procedure Protections.** Rescissions of coverage, including retroactive terminations due to alleged misrepresentation of fact (e.g., errors in the application for coverage) must be treated as adverse benefit determinations, which trigger the plan's appeals procedures. Rescissions for non-payment of premiums are not covered by this provision.

- **Communication Requirements in Non-English Languages.** Language assistance for non-English speaking claimants are required under some circumstances.

Next Steps

Before April 2018, employers should:

- Identify which benefit plans (in addition to long-term disability) it sponsors are subject to the final rule (and consider whether to amend any plan that currently triggers the new rules to rely on the disability determinations of another plan to avoid having to comply with the final rule);
- For any plan subject to the final rule, review and revise claims and appeal procedures prior to April if the plan is not already in compliance with the new rule;
- Update participant communications, such as summary plan descriptions and claim and appeal notices, as needed; and
- Discuss administration of disability benefits with any third-party administrators and insurers to ensure compliance.

This alert was prepared for Clark & Lavey Benefits Solutions, Inc. by Marathas Barrow Weatherhead Lent LLP, a national law firm with recognized experts on the Affordable Care Act. Contact Peter Marathas (pmarathas@marbarlaw.com), Stacy Barrow (sbarrow@marbarlaw.com) or Tzvia Feiertag (tfeiertag@marbarlaw.com)**.**

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