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ALERTS

New Disability Claims Procedures Effective In April 2018

March 22, 2018 | Atlanta | Chicago | Columbus | Dallas | Delaware | Elkhart | Fort Wayne | Grand Rapids | Indianapolis | Los Angeles | Minneapolis | San Diego | South Bend

Employee benefit plans that are subject to ERISA must comply with new disability claims procedures for claims filed after April 1, 2018.

What Plans Are Impacted by the Changes?

The new claims procedures generally apply to employee benefit plans that are subject to ERISA, that condition the availability of a benefit to the claimant on disability status and that require a plan administrator to make a determination regarding the claimant's disability. The new claims procedures apply to health and welfare plans that provide for disability benefits, including "wrap plans." An ERISA-covered retirement plan (e.g., defined benefit plan, defined contribution plan or top-hat plan) is subject to the new claims procedures if the determination of disability status impacts vesting, payment or calculation of a participant's benefits and the determination of disability is made by the plan administrator or its delegate (e.g., a physician chosen by the plan administrator). However, if the determination of disability in a retirement plan is made by the Social Security Administration or the insurer for the employer's disability plan, the retirement plan is not subject to the new claims procedures.

What Has Changed in the Disability Claims Procedures?

Discussion of Claim Denial and Contractual Limitations

The new claims procedures require a full discussion of all reasons related to a claim denial. This includes a discussion of the basis for disagreeing with any disability determination by the Social Security Administration, the views of health care professionals treating a claimant and the views of vocational professionals evaluating a claim, both provided by the claimant in connection with the claim and obtained on behalf of the plan in connection with any adverse benefit determination, whether or not relied upon in making the determination. An adverse benefit determination must now include an explanation of any denial related to medical necessity, experimental treatment or similar exclusion or provide a statement that such explanation will be provided free of charge upon request. An adverse benefit determination must also include a clear and prominent statement of any applicable contractual limitations period and the deadline (i.e., the calendar date) for bringing a related civil action.

Right to Access Claim File and Internal Protocols

The new claims procedures provide a claimant the right to access his entire claim file and other relevant documents. A statement of this right must be included in the adverse benefit determination. Previously, this right was only required to be stated in notices denying benefits on appeal.

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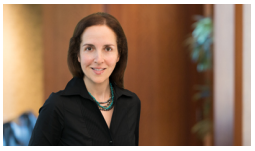

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RELATED PRACTICE AREAS

Benefits and Compensation

Claimants also must be informed of the internal protocols, guidelines and rules of a plan that were used in determining that a claim should be denied, or a statement that none were used. Prior to the new claims procedures, adverse benefit determinations were merely required to state that internal protocols, guidelines and rules were applied and that copies may be obtained upon request.

Right to Review New Information, Evidence and Rationale

The new claims procedures require that claimants be given notice of new information or evidence produced or a new rationale that is relied upon by the plan during the appeal process and an opportunity to review and respond to this new information, evidence or rationale before a final adverse benefit determination is made. The new information, evidence or rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of the decision must be provided to the claimant so that the claimant has a reasonable opportunity to respond prior to the notice date.

Avoidance of Conflicts of Interest

Claims and appeals must be reviewed in a manner that ensures impartiality and independence of the decision makers. No medical expert, for example, may be hired, terminated, compensated or promoted based on the likelihood of that individual denying a benefit claim.

Deemed Exhaustion of Claims and Appeals Process

If a plan fails to satisfy all the requirements for the administration of claims procedures, the claimant will be deemed to have exhausted administrative remedies, except where the failure is: (i) de minimis; (ii) non-prejudicial; (ii) attributable to good cause or matters beyond the plan's control; (iv) in the context of an ongoing good-faith exchange of information; and (v) not reflective of a pattern or practice of non-compliance. If administrative remedies are deemed exhausted, the claimant may immediately pursue a claim in court. In such case, even if the claim was already decided by the plan administrator, the court may apply a de novo, rather than deferential, standard of review, which may favor the claimant.

Coverage Rescissions May Be Adverse Benefit Determinations

A retroactive rescission of coverage is considered an adverse benefit determination, unless the rescission is attributable to a failure to timely pay required premiums or contributions toward the cost of coverage. A rescission that is treated as an adverse benefit determination will trigger the plan's appeal process.

Culturally and Linguistically Appropriate Disclosures

Notices and disclosures issued under the plan's claims procedures must be written in a "culturally and linguistically appropriate" manner, similar to rules applicable to other benefit communications. If at least ten percent of the population where the claimant resides is literate only in the same non-English language, plan notices and disclosures must include a statement prominently displayed in the applicable non-English language describing how the claimant can access language services.

What Steps Are Recommended for Plan Sponsors?

- Determine which employee benefit plans are impacted by the new claims procedures.
- Confirm that the new claims procedures are operationally in effect as of April 1, 2018 with respect to claims reviewed by insurers, third party administrators and employees responsible for claims administration.
- Review plan documents, summary plan descriptions, claims and appeal notices and administrative practices and procedures for affected retirement plans and health and welfare plans to determine if revisions are necessary. Plan documents should be amended by the end of the plan year that includes April 1, 2018.
- Distribute revised summary plan descriptions or summaries of material modifications to participants in affected plans.

For more information, please contact the attorney with whom you work, or the following members of Barnes & Thornburg LLP's Employee Benefits group: Lori Shannon at lori.shannon@btlaw.com or (312) 214-5664; Michael Paton at michael.paton@btlaw.com or (317) 231-7201; or Mina Amir-Mokri at mina.amir-mokri@btlaw.com or 312-214-4804.

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