New Disability Claim Procedures Effective April 1, 2018

The Department of Labor ("DOL") has announced that new disability claim procedures for ERISA covered employee benefit plans will become effective for disability claims submitted on and after April 1, 2018. Originally scheduled to become effective January 1, 2018, the DOL issued a 90-day delay in October 2017 to seek additional public comment on the impact the new procedures may have on stakeholders. On January 5, 2018, the DOL confirmed the April 1, 2018 effective date.

Employers sponsoring ERISA-covered plans that provide disability benefits should ensure that plan documents and employee materials such as summary plan descriptions are amended (or a summary of material modifications is prepared) to incorporate the new requirements.

Disability Claim Procedures

The final rule sets the following requirements for the processing of disability benefits and appeals:

- **Disclosure Requirements.** Benefit denial notices must contain a more complete discussion of why the plan denied a claim and the standards it used in making the decision.
- **Claim File and Internal Protocols.** Benefit denial notices must include a statement that the claimant is entitled to receive, upon request, the entire claim file and other relevant documents. In addition, the claimant must be guaranteed the right to show evidence and present testimony to support their claim during the review process. Currently, this statement is required only in notices denying benefits on appeal.
- **Review and Respond to New Information.** 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.
- **Conflicts of Interest.** Plans must ensure that disability benefit claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision.
- **Deemed Exhaustion.** 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). If the claimant is deemed to have exhausted the administrative remedies available under the plan, the claim or appeal is deemed denied on review without the exercise of discretion by a fiduciary and the claimant may immediately pursue his or her claim in court.
- **Coverage Rescissions.** 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, thereby triggering the plan's appeals procedures.
- **Communication Requirements in Non-English Languages.** Benefit denial notices must be provided in a non-English language in certain situations, using standards applicable to group health plan benefit notices under the ACA.

For additional information about our services, please contact Kyle Frigon at 404-733-3256 or via email at: kfrigon@cherrybekaertbenefits.com.