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CLIENT ALERT

Department of Labor Announces No Further Delay to Disability Claim Procedure Rules

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On January 5, 2018, the U.S. Department of Labor, Employee Benefit Security Administration (the "Department") announced there will be no more delays to the April 1, 2018 applicability date of final rules that amend claims procedure requirements applicable to ERISA-covered employee benefit plans that provide disability benefits ("Final Rule"), including retirement plans that provide for benefits upon disability.

The Final Rule originally became effective on January 18, 2017, and was scheduled to apply to claim determinations beginning on January 1, 2018. The Department subsequently announced a delay that extended the applicability date until April 1, 2018. The purpose of the delay was to enable the Department to consider comments and data as part of its effort to comply with Executive Order 13777. The Department characterized the Executive Order as requiring it to examine regulatory alternatives that meet its objectives of ensuring the full and fair review of disability benefit claims while not imposing unnecessary costs and adverse consequences. In its January 5, 2018 announcement, the Department noted that it received few substantive comments supporting assertions that the Final Rule would drive up disability benefit plan costs by more than the Department had predicted, or cause an increase in litigation, and consequently reduce workers' access to disability insurance protections.

As a background refresher, Section 503 of ERISA requires that every ERISA covered employee benefit plan establish and maintain reasonable procedures governing the filing of benefit claims, notification of benefit determinations, and appeal of adverse benefit determinations. A claimant may not file suit against a plan until it has exhausted the plan's administrative remedies. A plan's failure to follow these claim procedure rules may preclude the plan from arguing that a participant or beneficiary failed to exhaust the plan's administrative remedies, may result in a less favorable standard of review by a court (de novo versus arbitrary and capricious), and may even give rise to a breach of fiduciary duty.

The Final Rule adds several new requirements for the processing of claims and appeals for disability benefits, including the following:

- **Explanation of Reasons for Denial**
  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.

- **Statements Regarding 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 and also must include the internal rules, guidelines, protocols, standards, or other similar criteria used in denying a claim, or a statement that none were used.
- **Limitations on Denials Based on 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.
- **Avoidance of Conflicts of Interest**
  Claims and appeals must be adjudicated in a manner designed to ensure independence and impartiality. 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 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.
- **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.
- **Communication Requirements in Non-English Languages**
  Benefit denial notices have to be provided in a non-English language in certain situations.

As April 1, 2018 approaches, ERISA-governed benefit plans will need to be reviewed and revised prior to that date if the plans are not in compliance with these new rules. In addition, participant communications, such as summary plan descriptions and claim and appeal response letters, will need to be reviewed and may need to be revised. To the extent a plan sponsor and/or plan fiduciaries have delegated the review of disability-related claims to a third party, plan sponsors and/or plan fiduciaries will need to ensure that such third parties will abide by and follow the Final Rule. If claim or appeal decisions are handled in-house, individuals or committees that decide such claims and appeals will need to abide by these new procedures.

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