Published on *The National Law Review* https://natlawreview.com

Disability Claims Procedures Should be Updated for New Regulations

Article By:

Damian A Myers

James R Huffman

As open enrollment approaches for many benefit plans, employers and plans sponsors should check to make sure their claims procedures for disability claims are consistent with regulations that become effective for plan years beginning on and after January 1, 2018. These regulations apply to ERISA-covered short-term and long-term disability plans, as well as retirement plans that provide disability benefits that require disability determinations by the plan administrator (as opposed to relying on a Social Security Administration determination or long-term disability plan determination). The new disability claims procedures are largely meant to track, with some differences, the enhanced disclosure and claims procedures established for medical claims by the Affordable Care Act. Below are the key components that employers and plan administrators should consider.

1. Claims and appeals to be determined with impartiality. The new regulations emphasize independence and impartiality on the part of those making disability benefit determinations. This means that plan administrators cannot base their hiring, compensation, termination, or promotion decisions based on the likelihood that a claims adjudicator will deny a disability claim. The same is true for similar decisions made with respect to retaining medical or vocational experts.
2. More information in benefit denial notices. If a disability benefit claim is denied, plans must now include with such denial a detailed explanation for the denial. More specifically, the denial should include an explanation for disagreeing with or not following the views of health care professionals treating the claimant, the views of medical or vocational experts obtained on behalf of the plan, and a disability determination made by the Social Security Administration. This explanation is also required with respect to health care professionals and experts that the plan retained on its own. Additionally, if the denial is based on an exclusion or limit, such as medical necessity or experimental treatment, the plan must explain the scientific judgment for such determination, or at least state that such an explanation is available free of charge. Internal rules, guidelines, and protocols relied on in the denial must also be disclosed. Finally, claimants must receive timely notice of their right to receive copies of their files and other documents and records relevant to their disability claim determination.
3. Right to know about new evidence or new rationale on appeal. If the claims administrator relies on new information in determining the appeal of a disability benefit determination, the

claims administrator must disclose this information to the claimant and afford the claimant the opportunity to respond. The regulations do not provide insight as to what type of information is considered "new" for this purpose, but claims administrators should err on the side of disclosure.

4. Deemed exhaustion. The new regulations provide for deemed exhaustion of administrative remedies (which would allow claimants to go directly to court rather than complete the internal claims and appeals procedures) when a claims administrator fails to adhere to the regulation's requirements. Exceptions to this general rule apply when the violation is de minimis, non-prejudicial, attributable to good cause or to matters beyond the plan's control, or in the context of a good-faith exchange of information and not be reflective of a pattern or practice of non-compliance.
5. Extension to rescission of disability coverage. As with medical claims, a rescission of disability coverage is treated as an "adverse benefit determination," which triggers application of the new claims and appeals procedures.
6. Culturally and linguistically appropriate notices. The new regulations require that notices of adverse benefit determinations be provided in a "culturally and linguistically appropriate manner." Similar to ACA requirements, if a claimant's address is located in an area in which 10% or more residents are literate only in the same non-English language, claim or appeal denial letters must include a statement in the applicable non-English language regarding the availability of language assistance.
7. Contractual Limitations Periods. Many plans include contractual time limitations for when a claimant can sue under ERISA Section 502 following exhaustion of internal claims procedures. The proposed disability regulations requested comments on whether such limitations should be permitted. During the comment period, the United States Supreme Court ruled that contractual limitation periods are permissible. However, the new regulations provide a few guidelines. First, the contractual limitations period cannot end before the internal claims procedures are exhausted. Second, claimants must receive adequate disclosure of the contractual limitations period.

The new disability claim procedures will undoubtedly complicate disability claims administration. Nevertheless, these new procedures largely track the enhanced disclosure requirements under the Affordable Care Act. Therefore, plan administrators familiar with the ACA requirements should be well-equipped to apply the requirements to disability benefit determinations.

National Law Review, Volume VII, Number 213