INFOBRIEF

TOPIC: DOL UPDATED ERISA DISABILITY BENEFIT CLAIMS AND APPEALS PROCEDURES

ISSUED 02/05/18

Section 503 of ERISA generally requires employee benefits plans to provide written notice to any participant or beneficiary whose claim for benefits has been denied and to provide the claimant a full and fair process for review of the claims denial. In December 2016, the Department of Labor (DOL) issued final regulations, amending the ERISA claims and appeals procedures for disability benefit plans.

In general, an ERISA-governed plan is subject to the final regulations if benefits are conditioned on the plan's finding of disability. This includes plans providing benefits or rights contingent on a finding of the claimant's disability, such as 401(k) plans or pension plans, not just disability plans. These new disability claims procedure regulations do not apply to any plan that conditions a find of disability based on a determination made independently by a party other than the plan itself, such as the Social Security Administration or a different plan of the employer. The final regulations are applicable to disability benefit claims submitted after April 1, 2018. This date is not related to plan year.

Notable Changes to Disability Claims Rules:

Benefit Denial Notices

- Complete discussion explaining the basis for denial and the standards used in making the decision.
- An explanation of the basis for disagreeing with health care professionals, vocational professions, or the Social Security Administration.
- Statement informing the claiming he or she is entitled to receive, upon request and free of charge, reasonable access to and copies of the entire claim file and other relevant documents.
- Disclosure of specific internal rules, guidelines, protocols, standards or other similar crit used as a basis for the denial
- Notice and fair opportunity to respond to new information or additional evidence considered, relied on, or generated by the plan or decision maker in connection with the claim.
- The new information must be provided to the claimant, free of charge, as soon as possible.

Rights to Review

- Notice and fair opportunity to respond to new information or additional evidence considered, relied on, or generated by the plan or decision maker in connection with the claim. The new information must be provided to the claimant, free of charge, as soon as possible.

Opportunity to Submit Evidence

- Guaranteed the right to present evidence and testimony to support their claim during the review process.

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Independence and Impartiality

- Claims procedures must be designed to ensure the independence and impartiality of the persons involved in decision-making.
- Independence and impartiality apply to final decision makers and is extended to others who may support the benefit denial, such as vocational experts.

Deemed Exhaustion of Claims and Appeal Processes

- If plans do not adhere to all claims processing rules, claimant may seek court review of denial unless the violation was result of minor error and rationale provided for their assertion.

Rescissions of Coverage

- Rescissions of coverage treated as claims denial, triggering the plan's appeal procedures.
- Rescissions for non-payment of premiums are not covered by this provision.

Notices Written in a Culturally and Linguistically Appropriate Manner

- Required notices and disclosures, including notices of adverse benefit determinations, must be written in a culturally and linguistically appropriate manner. The final rule essentially adopts the ACA standard for group health benefit notices.