The final rule and disability claims procedures: Are you ready? Do you have to be?

By Jenny L. Holmes and Claire P. Rowland

On December 16, 2016, the Department of Labor (DOL) issued final regulations (known as the “Final Rule”) revising the minimum required procedures that must be followed by disability benefit plans and plans that make benefit payments conditioned on a participant’s disability. The Final Rule was effective January 18, 2017, and applies to any claims for disability benefits filed on or after January 1, 2018.

However, on September 21, 2017, the DOL sent a proposed rule to the Office of Management and Budget (OMB) for review. This proposed rule may either amend or delay the Final Rule. Although the OMB generally takes up to 90 days to review a proposed rule, given the Final Rule’s upcoming January 1, 2018, effective date it’s possible the OMB will complete its review in less than 30 days. If so, the provisions of the Final Rule, including its current January 1, 2018, effective date, may change.

The Final Rule imposes increased duties on plan administrators and fiduciaries for the review and determination of disability benefit claims. Despite the pending OMB review, because January 1, 2018, is quickly approaching, we encourage all plan sponsors to review their claims procedures, health and welfare plan documents, retirement plan documents, summary plan descriptions (SPDs), disability claims and appeals denial notices, and any other forms and documents containing claims procedure information, and update them to comply with the Final Rule. Although it might be possible to retroactively amend plan documents after January 1, 2018, we suggest completing any necessary updates by January 1, 2018, to ensure full compliance.

The key changes under the Final Rule (as it currently stands) include:

Additions to benefit denial notice requirements

Benefit denial notices must contain a more complete discussion explaining the basis for denial and the standards used to reach that decision. The Final Rule mandates the following additional disclosures:

— An explanation of the basis for disagreeing with or not following the views of health care professionals or vocational experts presented by the claimant to the plan or whose advice...
was obtained on behalf of the plan (regardless of whether the views were relied upon by the plan in denying the claim), or with disability determinations made by the Social Security Administration;

— If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the denial, applying the terms of the plan to the claimant’s medical circumstances (or a statement that such explanation will be provided free of charge upon request);

— A statement informing the claimant of his or her right to receive, upon request and free of charge, reasonable access to and copies of the entire claim file and other relevant documents;

— A disclosure of the specific internal rules, guidelines, protocols, standards or other similar criteria used as a basis for the denial (or a statement that no such criteria exist); and

— A description of any applicable contractual limitations periods applying to the claimant’s right to bring an action as well as the calendar date upon which any rights expire.

**Enhanced rights of review**

The Final Rule provides enhanced rights to claimants to review and respond to new information before the final decision on the claim. Before a plan denies a claimant’s appeal of a benefit denial based on a new or additional rationale or evidence, the plan must provide the claimant, free of charge, with any new or additional rationale or evidence considered, relied upon or generated in connection with the claim. Any such rationale or evidence must be provided to the claimant as soon as possible in order to give the claimant a reasonable opportunity to respond before a final determination of the claim is made.

**Independent and impartial review requirement**

The Final Rule requires that plans ensure all claims and appeals are decided independently and impartially. Conflicts of interest regarding benefit denials must be avoided. For example, plans cannot use incentives based on the number of benefit claim denials, nor may plans contract with a medical expert based on the expert’s reputation for certain outcomes in contested cases. In addition, decisions regarding hiring, compensation, termination, promotion or other similar matters regarding any individual may not be made based upon the likelihood that the individual will support the benefit claim denial.

**Deemed exhaustion of claims and appeals processes**

The Final Rule provides that if a plan fails to adhere to all of the requirements under the Final Rule, the claimant (with some limited exceptions) is automatically deemed to have exhausted all administrative remedies on the basis that the plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim, and the claimant will not be barred from suing the plan.

The claimant may request that the plan provide a written explanation for a failure to comply with the Final Rule. The plan must respond to the request within 10 days, and include a specific description of the basis, if any, for asserting that the failure should not result in the deemed exhaustion by the claimant of the plan’s administrative remedies.
**Certain coverage rescissions considered adverse benefit determinations**

The Final Rule amends the definition of an adverse benefit decision to include a rescission of disability benefit coverage that has a retroactive effect. Any rescission of coverage must be treated as an adverse benefit determination and will therefore trigger the plan’s appeals procedures regardless of whether there is an adverse effect on a benefit at that time. This does not include rescissions for non-payment of premiums.

**Culturally and linguistically appropriate notices**

A plan must provide notices and disclosures in a non-English language to claimants in any county identified by the Census Bureau as having 10% or more of its population literate only in the same non-English language. In addition, the plan must provide a notice in the non-English language upon request.

English versions of all notices must include a prominent statement in the applicable non-English language clearly indicating how to access language assistance.

Plans are also required to provide oral customer assistance in the non-English language upon request, including answering questions and assistance with filing claims and appeals in the non-English language.

If your plan’s claim procedures still need to be updated to ensure compliance with the Final Rule, or you have questions about how the potential regulatory delay may affect your efforts to comply with the rules applicable to disability claims procedures, please contact your Nixon Peabody benefits attorney or:

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