Issue Date: March 26, 2018

Attachment 1 – Detailed Overview of New Disability Claim Regulations

The regulations are intended to more closely align the claims procedures for disability plans with the requirements that exist for group health plans under the ACA.

INDEPENDENCE & IMPARTIALITY

Plan administrators must ensure that claims are adjudicated in a fair, impartial manner, and that administrators are not hired, terminated, compensated, or promoted based on the likelihood that the individual will support the denial of disability benefits.

ADVERSE BENEFIT DECISION NOTICES – CONTENT REQUIREMENTS

Adverse benefit decision notices must include the following:

1. A discussion of the decision, including a detailed explanation of the basis for disagreeing (or not) with:
   - The health care professionals and vocational professionals who treated/evaluated the claimant;
   - The views of medical or vocational experts whose advice was obtained by the plan (regardless of whether the advice was relied upon in making the benefit determination); and/or
   - A disability determination made by the Social Security Administration.

(Note that the existing requirement also remains:If an adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, the notice must include either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge upon request.)

2. A description of the internal rules, guidelines, protocols, standards, or other criteria of the plan that were used in denying a claim (or a statement that none were used).
3. For a denial notice at the initial claims stage, a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claimant's claim for benefits.

RIGHT TO REVIEW NEW INFORMATION

Plans cannot deny a claim upon appeal using information that wasn't used in the initial determination (i.e., new or additional evidence or a new or additional rationale) unless the claimant is provided an opportunity, free of charge, to review and respond to the new information. To comply with this requirement, a plan must send the new or additional evidence or rationale automatically to the claimant as soon as it becomes available to the plan.

DISABILITY CLAIMS TIMEFRAMES

In general, disability claims timing requirements follow those that apply to group health plans, except that the timeframe for disability claims is "45 days" instead of "60 days."

ADDITIONAL STATEMENTS

A plan's notification of benefit determination on review must include a statement describing any voluntary appeal procedures offered by the plan (and the claimant's right to obtain the information about such procedures), along with a statement of the claimant's

right to bring action under Section 502(A) of ERISA. The statement of the claimant's right to bring action must include any applicable contractual limitations period that applies to that right, including the calendar date on which the contractual limitations period expires for the claim.

STRICT ADHERENCE TO CLAIMS PROCEDURES

If plans fail to adhere to the claims processing rules, other than due to a violation resulting from a minor error, then the claimant is deemed to have exhausted the administrative remedies available under the plan and 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. If the court rejects the claimant's request for review, then the plan must treat a claim as re-filed on appeal upon the plan's receipt of the court's decision and must provide the claimant with a notice of the resubmission within a reasonable timeframe.

COVERAGE RESCISSIONS ARE ADVERSE BENEFIT DETERMINATIONS

The definition of an "adverse benefit determination" for plans providing disability benefits includes a rescission of disability benefits coverage that has a retroactive effective date, except in cases where a rescission is due to failure to timely pay premiums.

NOTICES TO BE WRITTEN IN A CULTURALLY AND LINGUISTICALLY APPROPRIATE MANNER

Notices must be written in a culturally and linguistically appropriate manner. The same standards that apply to group health plan notices under the ACA apply to disability benefit denial notices. (If a disability claimant's address is in a country where 10% or more of the population is literate only in the same non-English language, benefit denial notices must include a prominent statement in the relevant non-English language about the availability of language services. And a verbal customer assistance process must be provided and described in writing in the non-English language upon request.)

As always, should you have any questions, please contact your Parker, Smith & Feek Benefits Team. While every effort has been taken in compiling this information to ensure that its contents are totally accurate, neither the publisher nor the author can accept liability for any inaccuracies or changed circumstances of any information herein or for the consequences of any reliance placed upon it.