March 14, 2018

Are Your Qualified and Nonqualified Employee Benefit Plans in Compliance With the New ERISA Disability Claims Regulations?

Effective for claims filed after April 1, 2018, employee benefit plans governed by the Employee Retirement Income Security Act (ERISA) must comply with the US Department of Labor's new disability claims regulations.

What do the new disability claims regulations require?

The purpose of the new regulations is to ensure full and fair claims review procedures for any determination whether a claimant is "disabled" under the terms of an ERISA plan.

In many respects, these expanded requirements mirror the protections that were added by the Patient Protection and Affordable Care Act (ACA) for certain group health plan claims, such as requirements to avoid conflicts of interest, and to ensure that denial notices are delivered in a "culturally and linguistically appropriate manner." The regulations also adopt the ACA requirement to notify claimants if the plan is basing an appeal decision on any new evidence or rationale considered, relied upon, or generated by the claims administrator (or at its direction) during the pendency of the appeal, and to provide the claimant with sufficient time to respond before an adverse benefit determination is rendered (although they do not adopt the ACA rule automatically giving the plan more time to render a decision in such cases).

In several respects, the requirements for disability claims are more onerous than the ACA group health plan requirements. For example, denial letters for disability claims must include the following elements that are not required for other ERISA plan types:

- a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (1) the views presented by the claimant of health care and vocational professionals who treated or evaluated the claimant; (2) the views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit determination; and (3) a disability determination regarding the claimant made by the Social Security Administration; and
- either: (1) the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making the adverse benefit determination; or (2) a statement that such rules, guidelines, etc. do not exist. (Group health plans, in contrast, may instead state that a rule, guideline, protocol or similar criterion was relied upon without specifying its identity, and provide a copy free of charge upon request.)

If you have questions about whether your plan is affected or what you need to do, contact your Katten **Employee Benefits and Executive Compensation** professional to discuss the next steps. Because the changes apply to claims filed after April 1, reach out as soon as questions arise.

Russell E. Greenblatt
+1.312.902.5222
russell.greenblatt@kattenlaw.com

Gary W. Howell
+1.312.902.5610
gary.howell@kattenlaw.com

Austin S. Lilling
+1.212.940.8510
austin.lilling@kattenlaw.com

Kate U. Saracene
+1.212.940.6345
kate.saracene@kattenlaw.com

Robert A. Stone
+1.212.940.6343
robert.stone@kattenlaw.com

Gabriel S. Marinaro
+1.312.902.5409
gabriel.marinaro@kattenlaw.com

Andrew R. Skowronski
+1.312.902.5230
andrew.skowronski@kattenlaw.com

Shannon L. Smith
+1.212.940.6339
shannon.smith@kattenlaw.com

With respect to initial claim denials, the notice must also include 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 claim.

With respect to appeal denials, the notice must include a description of any plan-specific limitations period that applies to the claimant's right to bring a civil action, including the calendar date on which the contractual limitations period expires for the claim.

Which employee benefit plans need to be updated for the new disability claims regulations?

All ERISA employee benefit plans that condition a benefit upon a determination that a claimant is disabled are subject to the new rules. Plan sponsors should be mindful that disability determinations may be part of any type of ERISA employee benefit plan, not just those providing long-term or short-term disability benefits. For example, group health plans often extend coverage beyond age 26 for adult children who are disabled, and life insurance plans often provide a premium waiver for participants who are totally disabled. Likewise, some qualified and nonqualified retirement or deferred compensation plans include special provisions for disabled participants, such as accelerated vesting or early retirement options.

Not all plans conditioning a benefit on a claimant's disability, however, need to be amended in order to comply. For example, where a plan does not provide for its own fiduciaries to make a determination of disability—but instead defers to the determination made by the administrator of another plan (like the employer's long-term disability plan)—then only the terms of the other plan need to be amended. Examples include health plans that extend eligibility, or deferred compensation plans that provide accelerated vesting, to claimants who are receiving benefits under the employer's long-term disability plan or Social Security Disability Insurance (SSDI).

Similarly, even if a plan provides for its own fiduciaries to make a determination of disability, it may not need to be separately amended if the plan's terms incorporate by reference the disability claims and appeals procedures of another plan that has been amended. In such case, the plan's fiduciaries will simply need to follow the new procedures, and to update the claims and appeals denial notices to comply with the new rules.

In short, it is only those ERISA plans that condition a benefit upon a determination that a claimant is disabled, where the plan fiduciaries themselves have the discretionary authority to determine if a participant is disabled, and where the plan contains its own procedures for making such determinations, that need to be amended. Plans with this design feature will also need to issue a Summary of Material Modifications (SMM) to notify participants of the changes, and revise their claims and appeals notices.

ERISA Plans that are NOT likely required to make changes to comply with the new regulations include:

- those that do not condition any benefit upon a determination that a claimant is disabled;
- those that accept a disability determination from another plan or party, such as the employer's long-term disability plan or the Social Security Administration; and
- those that incorporate by reference the claims and appeals procedures of another plan that has been updated.

If a plan is affected by the new disability claims regulations, what steps should plan sponsors take and by when?

- **Identify which plans are affected.** The first step is to take an inventory of your ERISA benefit plans and determine whether the plan: (1) conditions a benefit upon a determination that a claimant is disabled; (2) provides that the plan fiduciaries themselves have discretionary authority to determine if a participant is disabled, or defers to the determination made by another plan; (3) contains its own procedures for making such determinations.
- **Update plan documentation.** Where the plan contains its own procedures for making disability determinations, the plan must be amended to comply with the new rules for any claims filed after April 1. Plan document amendments must be executed by the end of the plan year, and SMMs describing the changes must to be distributed to participants no later than 210 days after the end of the plan year. Plans where the fiduciaries themselves make a determination of disability may want

to consider amending the plan to accept the determination of disability by another plan (such as a long-term disability plan) or the Social Security Administration. Such a plan design change would generally require an amendment by April 1.

- **Update denial notices and coordinate with insurers/third-party administrators.** Where the plan fiduciaries themselves have discretionary authority to determine if a participant is disabled, they will need to make such determinations in accordance with the new procedures for any claims filed after April 1, and must ensure that claims and appeals denial notices have been updated to comply. Even where the plan has delegated discretionary authority to an insurer or Third-Party Administrator (TPA) to make such determinations and issue denial letters, the insurer or TPA may need to customize their standard notice templates to accommodate unique provisions of the employer's plan. For example, where employer's plan document contains a statute of limitations that restricts the length of time a claimant has to bring a civil action, the insurer or TPA will need to customize appeal denial letters to reflect the limitations period and include the calendar date on which the limitations period expires for the claim.

Attorney advertising. Published as a source of information only. The material contained herein is not to be construed as legal advice or opinion.

©2018 Katten Muchin Rosenman LLP. All rights reserved.

Katten refers to Katten Muchin Rosenman LLP and the affiliated partnership as explained at kattenlaw.com/disclaimer.