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Authors:

[Carl C. Lammers](#)

Employers: Prepare to Address Disability Claims Under all Types of Benefit Plans Differently, Effective April 1, 2018

Beginning April 1, 2018, employers will need to be prepared to address Department of Labor (DOL) final regulations expanding the requirements for claims based on a “disability” under a wide variety of benefit plans. Any ERISA-covered benefit plan that provides a different right to participants who meet a definition of disability—for example, faster vesting, sharing in a year-end retirement allocation despite low active work hours, or receipt of disability income-replacement benefits—will be impacted by these new rules. Plan sponsors will need to review their plan documents and summary plan descriptions (SPDs) to modify written claims procedures, and, most important, must be ready to address disability decisions in operation in compliance with the new rules very quickly.

If disability decisions made on or after April 1, 2018, do not comply with the new disability claims procedures, and the claim is later litigated, a court will review the issues “de novo” and give no deference to an administrative determination, nor limit review to the facts and documents that were assembled as the administrative record.

Here is a brief overview of the changes:

- **Independence and Impartiality; Avoiding Conflicts of Interest.** Plans must now (i) “ensure that all claims and appeals for disability benefits are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision” and (ii) ensure that decisions regarding hiring, compensation, termination, promotion, etc. with respect to professionals involved in disability claims decision-making (such as claims adjudicators or medical or vocational experts) are not made based on the

likelihood that the individual will support denial of disability benefits.

- **Additional Disclosure Requirements.** Plans must provide additional pieces of information with respect to a disability claim denial, including: (i) a discussion of the decision, including an explanation of the basis for disagreeing with or not following the views of a treating physician or vocational professional who evaluated the claimant, regardless of whether the information was presented by the claimant or otherwise obtained on the plan's behalf, and any disagreements with a Social Security Administration disability determination presented by a claimant; (ii) if claim denial is based on medical necessity or experimental treatment (or similar reason), an explanation of the scientific or clinic judgment for the determination (or a statement that the explanation will be provided free of charge); (iii) the specific internal rules, guidelines, protocols, standards, or other similar criteria that the plan relied upon in denying the claim (or a statement that these do not exist); and (iv) a statement that the claimant is entitled to receive, upon request, documents relevant to the claim. A claim denial notice must also include a description of any applicable contractual limitations period and the expiration date relevant to the claim.
- **Right to Review and Respond to New Information Before Final Decision.** Plans must provide, free of charge, and prior to denying an appeal, any new or additional evidence or rationale for denial considered, relied upon, or generated by (or at the direction of) the plan, insurer, or other person making the benefit determination in connection with the appeal. The evidence or rationale must be provided "as soon as possible and sufficiently in advance of the date that the plan's decision on appeal is due, to give the claimant a reasonable opportunity to respond to such new or additional evidence or rationale." If the plan does not provide the new evidence or rationale in accordance with the above, the plan cannot rely on that new evidence or rationale in denying the appeal.

- **Deemed Exhaustion of Claims and Appeals Processes.** The rules that provide for the administrative claims procedure to have been deemed exhausted (which must occur before a participant can make a claim in court) have been revised to provide that if a plan fails to strictly adhere to all the rules for processing disability claims, a claimant will be deemed to have exhausted the plan's claims procedures and may file a lawsuit, unless the "minor errors" exception applies. The "minor errors" exception applies only when a violation of the required claims procedures was (i) de minimis, (ii) non-prejudicial, (iii) attributable to good cause or matters beyond the plan's control, (iv) in the context of an on-going good faith exchange of information, and (v) not reflective of a pattern or practice of noncompliance. Claimants are also entitled, upon request, to an explanation of the violation from the plan, with the plan having 10 days to respond. A claimant who is not satisfied with or does not request an explanation may file suit. The court will decide whether the plan strictly adhered to the claims procedure rules or whether the minor errors exception applies. If claimant's suit is rejected by the court due to the plan satisfying the minor errors exception, the claim will be sent back to the plan to finish the appeal process.
- **Coverage Rescissions; Adverse Benefit Determinations.** The definition of an "adverse benefit determination" (from which a participant can appeal) has been amended to include any rescission of disability benefit coverage that has a retroactive effect, except to the extent the rescission is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.
- **Culturally & Linguistically Appropriate Notices.** Adverse benefit determinations must now be provided in a "culturally and linguistically appropriate manner" if a claimant's address is in a county where 10 percent or more of the population of that county are literate only in the same non-English language.

Employer Action Steps:

1. **Identify Plans with Disability Triggers.** Employers must first determine which plans they maintain that include rights that

vary if a participant is disabled. This list generally will include more than just the obvious long-term disability income program. For example:

- A short-term disability plan may need to comply, if it is more than a “payroll practice” and thus not exempt from ERISA.
- A 401(k) Plan may include an employer contribution that becomes 100 percent vested if a participant becomes disabled while employed by the plan sponsor.
- A profit sharing plan might condition receipt of a share of a contribution on a participant remaining employed until year end, or working up to 1,000 hours in a year, and those terms often make exceptions if the person failed to meet the standard as a result of becoming disabled.
- Occasionally, a retirement plan might allow a distribution upon the occurrence of a disability, even before the disability has resulted in a termination of the employment relationship.
- A life insurance program might waive further payment of premiums for any period while the participant is disabled.
- A pension plan might allow retirement income to begin earlier, sometimes at the same level of income as if the participant were retirement age, if a participant becomes disabled. Or, a pension might continue to count a period when someone is receiving a long-term disability income benefit as service for purposes of calculating the participant’s benefit.
- Nonqualified deferred compensation or supplemental retirement plans (sometimes referred to as “top hat” plans), which have different benefits, payment terms or entitlements based on disability.

2. Who Decides? Does a third party (external) reviewer determine if disability exists? If so, either the plan document, insurance contract or service agreement (as applicable) needs to require that that third party comply with the new DOL rules.

3. Update Documents. Many benefit plans detail claims procedures only in the SPD; in that case, the plan document might not need to be updated, but a summary of material modifications should be provided to plan participants outlining the disability claims procedure changes. Fast action is needed for a plan that is primarily focused on providing disability income, but most employers will find they rely on an insurance carrier or third-party administrator to make the needed operational and document changes on these plans.

The less obvious application of these rules to other types of benefits programs—like retirement plans—will place a higher burden on employers for analysis and action before the first disability claim is received after April 1, 2018. Employers should note that retirement plan platform providers seldom make claims decisions, but rather rely on the employer to direct if a participant meets a plan requirement. Further, most pre-approved retirement plan documents do not include a claims procedure (referring instead to a SPD) and the document provider generally only provides a sample SPD for which updates are not routinely offered. We expect that many retirement plan sponsors will prefer to minimize or eliminate their involvement in disability decisions in the wake of the new rules. This alone may require a plan amendment and perhaps changes in service agreements.

If you have any specific questions on if and how the new disability claim and appeal rules affect your benefit plans, please contact [Carl Lammers](#) or any other attorney in Frost Brown Todd's [Employee Benefits Group](#).

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