On December 19, 2016, the Department of Labor Employee Benefits Security Administration (DOL) released a final regulation (“Final Rule”) under Section 503 of ERISA applicable to claims procedures for plans that provide disability benefits. The Final Rule strengthens ERISA’s current claims procedure rules for disability claims by adopting certain enhanced procedural protections and safeguards currently applicable to group health plan claims under the Affordable Care Act (ACA).

Plan administrators, third party administrators (TPAs) and service providers must comply with the Final Rule, which is applicable to all claims for disability benefits filed on or after January 1, 2018. The DOL also released a helpful Fact Sheet that provides a good summary of how the Final Rules work.

**Background**

ERISA’s claim procedure rules generally require that plan administrators provide adequate notice in writing to participants or beneficiaries whose claims for benefits under a group health plan have been denied. Also required are specific reasons for the denial written in plain language that can be understood by a participant, and a reasonable opportunity for a fair review by the appropriate plan fiduciary.

**How Does the New Rule Work?**

The Final Rule applies these claims procedures for group health plans to disability benefits claims. In general, a benefit is a disability benefit subject to the disability claims regulations in the Final Rule if a plan conditions the benefit’s availability on a showing of disability (and notably, this definition applies regardless of how the plan characterizes the benefit or whether the plan is a health or retirement plan).

The new rules are intended to make it easier for participants whose disability benefits might have been denied incorrectly to receive benefits and to alleviate some of the hardships associated with losing earnings due to becoming disabled.

The Final Rule requires:

- **Plans providing disability benefits** must ensure that all claims and appeals for benefits are adjudicated in a manner which ensures independence and impartiality of the claims decision makers in accordance with Section 503 of ERISA’s basic fiduciary standards to ensure a full and fair review process and to avoid conflicts of interest.

- **Claim denials for disability benefits** have to include additional information, including a discussion of any disagreements with the views of medical and vocational experts as well as additional internal information relied upon in denying the claim. A plan cannot decline to provide internal rules, guidelines and protocols by claiming they are proprietary.

- **Notices** have to be provided in a “culturally and linguistically appropriate manner.” If the claimant lives in a county where the U.S. Census Bureau says at least 10% of the population is literate only in a particular language (other than English),...
the denial has to include a statement in that language saying language assistance is available. The plan must then provide a customer assistance service (e.g., a phone hotline) and must provide notices in that language upon request.

- New or additional rationales or evidence considered on appeal must be provided as soon as possible and so that the claimant has an opportunity to respond before the claims process ends.

- If the claims rules are not followed strictly, then the claimant can bypass them and go straight to court. Specifically, with limited exceptions, a claimant will be deemed to have exhausted the plan’s claims and appeals administrative processes if the plan doesn’t adhere to all claims procedure requirements. This does not apply to small violations that don’t prejudice the claimant.

- As with health plan claims, rescissions of coverage are treated like claim denials.

- If a plan has a built-in time limit for filing a lawsuit, a denial on appeal has to describe that limit and include the date on which it will expire (i.e., claimants have to know that they need to sue by a specific date). The DOL noted that, while this only applies to disability-related claims, they believe any plan with such a time limit is required to include a description or discussion of it under the existing claims procedure regulations.

**When Does the Final Rule Go Into Effect?**

The Final Rule is effective January 18, 2017, and affects claims that occur on or after January 1, 2018.

**How Does This Affect Employers? Are the Rules Different for Insured Disability Plans?**

All plan sponsors should review and understand these new procedural requirements. If the provisions of the Final Rule are not adhered to, disability claims that may have been rightfully denied may have to be paid based on an employer-sponsored plan’s failure to follow administrative procedures, incurring additional costs. Employers should review their plan documents, SPDs and benefits policies to ensure that they are consistent with the Final Rule.

While insurance carriers for insured plans typically take responsibility for plan administration and claims procedures, plan sponsors can still be subject to lawsuits and higher claims costs if these procedures do not work. Given that some insurance carriers may be slow to adopt these new procedures, employers sponsoring insured disability plans should start a discussion with their insurance carriers about how these procedures will apply to them and what changes are needed to their Certificates of Insurance.

If you have any additional questions, please call your Corporate Synergies Account Manager or 866.CSG.1719.