COMPLIANCE BULLETIN

DOL Strengthens Rules for Disability Benefit Claims

HIGHLIGHTS

- Group health plans must comply with strict requirements for deciding benefit claims.
- According to the DOL, employees who request disability benefits deserve the same protections.
- The final rule adds new protections for disability benefit claims to make them more consistent with the rules for group health plan claims.

IMPORTANT DATES

January 1, 2018

The final rule's changes are applicable to claims submitted on or after Jan. 1, 2018.

OVERVIEW

On Dec. 16, 2016, the Department of Labor (DOL) released a final rule to strengthen the claims and appeals requirements for plans that provide disability benefits. According to the DOL, these new protections will ensure that disability claimants receive a full and fair review of their benefit claims, as required by the Employee Retirement Income Security Act of 1974 (ERISA).

The new requirements provide disability claimants with protections that are similar to those that apply when employees file claims for group health benefits. The new requirements are intended to protect disability claimants from conflicts of interest, increase the transparency for benefit denials and provide claimants with a more effective opportunity to respond to the evidence and reasoning behind the benefit decision.

ACTION STEPS

ERISA plans that include disability benefits must comply with the new procedural protections for disability benefit claimants, effective for disability claims that are submitted on or after **Jan. 1, 2018**.

Entities that administer claims for these plans, including issuers and third-party administrators, will need to revise their claims procedures to comply with the final rule's requirements.

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ERISA Requirements

Section 503 of ERISA requires every employee benefit plan to:

- ✓ Provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the **specific reasons** for the denial, written in a manner calculated to be understood by the participant; and
- ✓ Afford a reasonable opportunity to any participant whose claim for benefits has been denied for a **full and fair review** by the appropriate named fiduciary of the decision denying the claim.

The DOL first adopted claims procedure regulations for employee benefit plans in 1977. In 2000, the DOL updated its claims procedure regulations by improving and strengthening the minimum requirements for employee benefit plans, including plans that provide disability benefits.

"Disability benefits are a lifeline for workers who are unable to work after becoming disabled. Claimants deserve to know how decisions are made. They and their families should also have confidence that the process and procedures are not biased against them." – Phyllis C. Borzi, EBSA Assistant Secretary

Effective for plan years beginning on or after Sept. 23, 2010, the Affordable Care Act (ACA) amended ERISA to include enhanced internal claims and appeals requirements for group health plans.

Additional Protections for Disability Claimants

According to the DOL, it can be challenging for workers seeking disability benefits from an employer-sponsored plan to understand the process and why their claim is approved or denied. To improve the fairness, transparency and accuracy of the disability claims process, the final rule requires that plans, plan fiduciaries and insurance providers comply with additional procedural protections when dealing with disability benefit claimants.

What Is a Disability Benefit? A benefit is considered a "disability benefit" if the claimant has to be disabled in order to obtain the benefit. It does not matter how the benefit is characterized or whether the plan as a whole is a retirement plan or a welfare plan. If the claims adjudicator must make a determination of disability in order to decide a claim, the claim must be treated as a disability claim for purposes of the DOL's claims procedures.

The final rule includes the following requirements for the processing of claims and appeals for disability benefits:

- ***Improvement to Basic Disclosure Requirements:*** Benefit denial notices must contain a more complete discussion of why the plan denied a claim and the standards used in making the decision.
- ***Right to Claim File and Internal Protocols:*** Benefit denial notices must include a statement that the claimant is entitled to receive, upon request, the entire claim file and other relevant documents. Benefit denial notices also have to include the internal rules, guidelines, protocols, standards or other similar criteria of the plan that were used in denying a claim or a statement that none were used.

- ***Right to Review and Respond to New Information Before Final Decision:*** The final rule prohibits plans from denying benefits on appeal based on new or additional evidence or rationales that were not included when the benefit was denied at the claims stage, unless the claimant is given notice and a fair opportunity to respond.
- ***Avoiding Conflicts of Interest:*** Plans must ensure that disability benefit claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. For example, a claims adjudicator or medical or vocational expert could not be hired, promoted, terminated or compensated based on the likelihood of the person denying benefit claims.
- ***Deemed Exhaustion of Claims and Appeal Processes:*** If plans do not adhere to all claims processing rules, the claimant is deemed to have exhausted the administrative remedies available under the plan, unless the violation was the result of a minor error and other specified conditions are met. If the claimant is deemed to have exhausted the administrative remedies available under the plan, 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.
- ***Certain Coverage Rescissions Are Adverse Benefit Determinations Subject to the Claims Procedure Protections:*** Rescissions of coverage, including retroactive terminations due to alleged misrepresentation of fact (for example, errors in the application for coverage) must be treated as adverse benefit determinations that trigger the plan's appeals procedures. Rescissions for nonpayment of premiums are not covered by this provision.
- ***Notices Written in a Culturally and Linguistically Appropriate Manner:*** Similar to the ACA standard for group health plan notices, the final rule requires that benefit denial notices be provided in a culturally and linguistically appropriate manner in certain situations.

Source: DOL's Employee Benefit Security Administration (EBSA)