

Fact Sheet



U.S. Department of Labor
Employee Benefits Security Administration
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Final Rule Strengthens Consumer Protections for Workers Requesting Disability Benefits from ERISA Employee Benefit Plans

On December 16, 2016, the Department of Labor announced the release of a Final Rule to strengthen consumer protections for private-sector workers making claims for benefits from their workplace disability insurance plans. This action ensures that disability claimants will receive a full and fair review of their claims, as required by ERISA section 503. This final rule will promote fairness and accuracy in the claims review process and protect participants and beneficiaries in ERISA-covered disability plans. The rule will help many disabled individuals avoid financial and emotional hardship by ensuring that they receive benefits that otherwise might have been denied by plan administrators, without the fuller protections provided by this final regulation.

Background

Section 503 of ERISA generally requires employee benefit plans to provide written notice to any participant or beneficiary whose claim for benefits has been denied, and to provide the claimant a full and fair process for review of the claims denial. The new rules add important procedural protections and consumer safeguards for claims for disability benefits. They protect claimants from conflicts of interest, increase transparency, and ensure that claimants have a fair opportunity to respond to the evidence and reasoning behind the decision. The rules also ensure that protections for disability claimants parallel protections that already apply when workers file claims for group health benefits.

On November 18, 2015, the Department published in the Federal Register a Notice of Proposed Rulemaking (NPRM) regarding the claims procedure for plans providing disability benefits. The Department received 145 public comments from interested stakeholders, including plan participants, consumer groups representing disability benefit claimants, plan sponsors, employer groups, individual insurers, and trade groups representing disability insurance providers.

Overview of Final Regulation

The final rule amends the Department's current claims procedure regulation at 29 C.F.R. §2560.503-1 for disability benefits to require that plans, plan fiduciaries, and insurance providers comply with additional procedural protections when dealing with disability benefit claimants. Specifically, the final rule includes the following improvements in the 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. For example, the notices must include a discussion of the basis for disagreeing with a disability determination made by the Social Security Administration if presented by the claimant in support of his or her claim.

- **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. Currently this statement is required only in notices denying benefits on appeal. 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. Currently, instead of including these internal rules and protocols, benefit denial notices have the option of including a statement that such rules and protocols were used in denying the claim and that a copy will be provided to the claimant upon request.
- **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. The final rule also provides that the plan must treat a claim as re-filed on appeal upon the plan's receipt of a court's decision rejecting the claimant's request for review.
- **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 (e.g. errors in the application for coverage) must be treated as adverse benefit determinations, thereby triggering the plan's appeals procedures. Rescissions for non-payment of premiums are not covered by this provision.
- **Notices Written in a Culturally and Linguistically Appropriate Manner.** The final rule requires that benefit denial notices have to be provided in a culturally and linguistically appropriate manner in certain situations. The final rule essentially adopts the ACA standard for group health benefit notices. Specifically, if a disability claimant's address is in a county where 10 percent 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. The plan would also be required to provide a verbal customer assistance process in the non-English language and provide written notices in the non-English language upon request.

The final rule largely adopts the improvements described in the Notice of Proposed Rulemaking, but some notable changes from the proposal are:

1. the list of examples of persons involved in the decision-making process who must be insulated from the plan's conflicts of interest has been modified to expressly include vocational experts along with claims adjudicators and medical experts;
2. the final rule clarifies that adverse benefit determinations must contain a discussion of the basis for disagreeing with 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, without regard to whether the advice was relied upon in making the benefit determination; and
3. the final rule requires notices of adverse benefit determinations on review to include a description of any applicable contractual limitations period and its expiration date.

The final rule is effective thirty (30) days after its publication in the Federal Register, and the improvements in the claims procedure process are generally applicable to disability benefit claims submitted on or after January 1, 2018.

For Further Information

The Federal Register notice for the final rule, including the amendments to the current rule, a discussion of the public comments, and the economic impact and paperwork burden analysis, is available on EBSA's website at www.dol.gov/agencies/ebsa. EBSA's website also includes other compliance assistance information to assist employers and employee benefit plan officials in understanding and complying with the requirements of ERISA as it applies to the administration of employee retirement, health and other welfare benefit plans.

This fact sheet has been developed by the U.S. Department of Labor, Employee Benefits Security Administration. It will be made available in alternate formats upon request: Voice Telephone: (202)693-8664; Text Telephone: (202)501-3911.

The information in this fact sheet constitutes a small entity compliance guide for purposes of the Small Business Regulatory Enforcement Fairness Act of 1996.