New rules will apply to disability benefit claims and appeals under certain plans that are subject to the Employee Retirement Income Security Act of 1974 (ERISA), effective for claims made after April 1, 2018. According to the Department of Labor (DOL), the new rules are intended to provide greater protection to claimants, and are modeled on the enhanced claims and appeals procedures that apply to health benefit claims under the Affordable Care Act (ACA).

The new rules will apply to disability benefit claims under both pension and welfare plans, but only if the plan’s claims adjudicator must make a determination of disability in order to decide the claim. If a plan conditions eligibility for benefits on a finding of disability by a third party, such as the Social Security Administration (SSA) or an employer’s long-term disability plan, the plan is not subject to the new rules. Plans may be amended to condition eligibility on a determination of disability made by the SSA or the employer’s long-term disability plan to avoid the application of the new rules described in this alert.

The new rules make seven significant changes to the current claims and appeals rules set forth in DOL regulations.

First, and perhaps most importantly, if a plan fiduciary does not strictly adhere to the new rules, its decision to deny benefits may not be entitled to deference by a reviewing court. Under current ERISA caselaw, a reviewing court will generally defer to a plan fiduciary’s claim denial using an arbitrary and capricious standard, so long as the plan document vests the fiduciary with discretion to decide claims. If there is no such authority, or if the fiduciary is operating under a conflict of interest, the reviewing court generally applies “de novo” review, meaning no deference is given to the fiduciary’s decision. The new rules provide that a denial made without strict adherence to the rules will be deemed denied without the exercise of fiduciary discretion. In that case, a reviewing court would have no basis for deferring to the fiduciary’s decision, which would likely result in de novo review. This rule does not apply to minor errors that do not prejudice the claimant, and are due to good cause or matters beyond the plan’s control.

The second change requires plans to ensure that claims are
determined by an independent and impartial adjudicator, to avoid a conflict of interest. This means that decisions about hiring, compensation, termination, or promotion of any individual cannot be based on the likelihood that the individual will support claim denials. This rule applies to ultimate decision makers, including third-party claims administrators, as well as medical and vocational experts.

Third, the new rules require enhanced disclosures following a claim denial. Under the new rules, a claim denial notice must contain a complete discussion of why the plan denied the claim, the standards applied in making the decision, and the basis for any disagreement with the views of medical or vocational experts who treated or evaluated the claimant. The notice must also explain any disagreement with a third-party, such as the SSA. If applicable, the notice must explain why the plan disagreed with any of its own experts.

A denial notice must also include the internal rules, guidelines, protocols, standards or other similar criteria on which the claims adjudicator relied, or a statement that such criteria do not exist. Further, a denial notice must describe the claimant’s right to receive relevant documents upon request and free of charge. Previously this description was required only in appeal denial notices.

The fourth change requires that plans automatically and free of charge give claimants any new evidence or rationale for the denial generated during the appeal process, and provide claimants a reasonable opportunity to respond to the new information before the appeal is decided. Under this rule, plans must permit a claimant to present written, audio or video testimony during the appeal phase.

Fifth, a rescission of disability coverage that has a retroactive effect, other than for non-payment of premiums, is treated as an adverse benefit determination subject to the new rules. It is unclear whether plans must continue to provide coverage pending a final determination on appeal of a rescission, as is the case for health plans.

Sixth, claim and appeal denial notices must include information about how a claimant can obtain language assistance from the plan in applicable non-English languages. Applicable non-English languages are determined on a county-wide basis, if at least 10 percent of the population is literate only in the language. Plans must have oral language assistance available to claimants in those languages, and provide written notices in any of the applicable languages, upon request. The DOL updates the list of applicable languages periodically, based on U.S. Census Bureau results. For California, the current applicable languages are Spanish (in several counties) and Chinese (in San Francisco only).

Finally, in addition to a statement of the claimant’s right to file a lawsuit under ERISA, an appeal denial notice must describe any limitations period for filing such a lawsuit that applies under the terms of the plan, including the calendar date on which the plan’s limitation period expires.

The new rules were published in the Federal Register on December 19, 2016, with an initial applicability date of January 1, 2018. In response to comments from stakeholders, the DOL delayed implementation of the new rules, but only for 90 days. On November 29, 2017, the DOL confirmed the applicability date of the new rules is April 2, 2018.

In addition to reviewing, and where necessary, modifying claims and appeals procedures to ensure compliance with the new rules, employers should review plan documents to determine whether amendments are required to incorporate the new rules. Employers may also consider, revising plan eligibility requirements to avoid application of the rules, as described above.

Plan sponsors with questions about the new ERISA Disability Benefit Claims and Appeals Rules can
contact Hanson Bridgett Employee Benefits Group.

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