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January 19, 2016

Office of Regulations and Interpretations  
Employee Benefits Security Administration  
Room N-5655  
U.S. Department of Labor  
200 Constitution Avenue, NW  
Washington, DC 20210

Re: Claims Procedure Amendment for Plans Providing Disability Benefits

Submitted Electronically: [www.regulations.gov](http://www.regulations.gov)

Dear Sir/Madam:

America's Health Insurance Plans (AHIP) is writing to offer comments in response to the Notice of Proposed Rulemaking on the Claims Procedure for Plans Providing Disability Benefits (the "Proposed Rule"). The Proposed Rule was published by the Department of Labor (DOL) in the *Federal Register* on November 18, 2015 (80 Fed. Reg. 72014). AHIP's members provide insurance coverage to and administer benefits on behalf of group health plans that provide short-term and long-term disability income insurance.<sup>1</sup>

According to the Preamble to the Proposed Rule, DOL proposes to "uplift the current standards applicable to the processing of claims and appeals for disability benefits so that they better align with the requirements regarding internal claims and appeals for group health plans under the regulations implementing the requirements of the Affordable Care Act." (80 Fed. Reg. 72015). These changes are intended to ensure a full and fair review of claims and appeals as required by Section 503 of the Employee Retirement Income Security Act (ERISA).

AHIP believes the current rules provide extensive protections for claimants and that DOL (along with state regulators in the case of disability income insurance carriers) has the enforcement tools necessary to deal with any group disability plans that may not act in a responsible manner with respect to disability benefits. As discussed below, the rationale suggested by the DOL for the Proposed Rule – namely that "insurers and plans looking to contain disability benefit costs are often motivated to aggressively dispute disability claims" (80 Fed. Reg. 72016) – is unfounded, and the potential costs of the new standards are significantly underestimated.

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<sup>1</sup> For purposes of our comments, the term "disability income insurance" includes insured and self-funded coverage for disability income protection benefits offered through a group health plan.

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If DOL intends to modify the current claims rule applicable to disability income claims, we offer a number of recommendations to streamline those proposals in a manner that protects the rights of claimants while not unduly increasing compliance or litigation costs that are ultimately passed on to employers offering disability income insurance. As DOL is aware, increased costs result in fewer employers offering coverage, which in turn places additional burdens on state and federal disability programs. Our comments in this letter address the following issues: (a) the scope and purpose of disability income protection benefits; (b) differences between disability determinations and claims for health benefits governed by the Affordable Care Act (ACA); (c) potential cost impacts of the Proposed Rule; and (d) recommended changes to the new standards.

### **Scope and Purpose of Disability Income Protection Benefits**

According to the most recent data from the U.S. Bureau of Labor Statistics, 39 percent of private industry workers participate in short-term disability insurance programs and 33 percent participate in long-term disability insurance programs.<sup>2</sup> Employer-sponsored disability income insurance provides income replacement to employees who experience an event that results in their inability to work. Short-term disability income insurance typically provides benefits for up to six months with coverage starting between 1 and 30 days after the date of disability. Long-term disability insurance generally begins between 90 and 180 days after the date of disability and continues up to age 65. Benefits are tied to salary (e.g., 60 percent of pay) and may also include overtime, bonuses, and commission compensation.<sup>3</sup>

In general, a “disability” that triggers coverage is a sickness, illness or injury that makes it impossible for the employee to perform the major duties of his or her occupation. Long-term disability insurance is generally based on the inability of workers to perform either the job duties in which they were previously engaged in (an “own occupation” policy) or any gainful employment (an “any occupation” policy). Depending on the coverage terms, income benefits may be available either for someone partially or fully disabled.<sup>4</sup> Based on data with respect to recently filed claims, the majority of triggering events are illnesses due to: (a) musculoskeletal and connective tissue damage (29 percent); (b) cancer and neoplasms (15 percent); (c) injuries and poisonings (10 percent); (d) cardiovascular and circulatory conditions (9 percent); and (e) mental disorders (8 percent).<sup>5</sup>

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<sup>2</sup> “Workers with Disability Insurance Plans,” The Economics Daily, U.S. Bureau of Labor Statistics, March, 4, 2015, accessed at: <http://www.bls.gov/opub/ted/2015/disability-insurance-plans-for-workers.htm>

<sup>3</sup> “Disability Insurance: A Missing Piece in the Financial Security Puzzle,” America’s Health Insurance Plans and the Society of Actuaries, October 2004, accessed at: <http://www.actuarialfoundation.org/publications/disability.shtml>

<sup>4</sup> “Managing Disability Risks in an Environment of Individual Responsibility,” Advisory Council on Employee Welfare and Pension Benefit Plans, December 2012, accessed at: <http://www.dol.gov/ebsa/publications/2012ACreport2.html>

<sup>5</sup> “2004 Long Term Disability Claims Review,” Council for Disability Awareness, accessed at: [http://www.disabilitycanhappen.org/research/CDA\\_LTD\\_Claims\\_Survey\\_2014.asp](http://www.disabilitycanhappen.org/research/CDA_LTD_Claims_Survey_2014.asp)

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One of the primary benefits of disability income insurance is helping workers and their families avoid financial hardship by replacing lost income and helping individuals return to work through programs that address functional limitations such as modifications to the work environment, facilitation of part-time work, development of new job skills, and integration of health and disability support services.<sup>6</sup> These protections, in turn, lessen the financial impact that would otherwise be placed on federal and state public assistance programs.

Two analyses by Charles River Associates for AHIP examined the positive impact of the availability of disability income insurance on public programs. One analysis considered the benefits to the federal treasury in reducing the number of individuals receiving Social Security Disability Insurance (SSDI) and other assistance (e.g., Medicare, Medicaid, and the Supplemental Nutritional Assistance Program) because the recipient either did not need the federal benefits or was able to return to work sooner. According to the report, the currently available private long-term disability insurance programs are expected to save the federal treasury approximately \$25 billion over the next 10 years through a reduction in SSDI benefits (\$10 billion) and other federal assistance (\$15 billion).<sup>7</sup> Similar benefits were found at the state level – a second analysis by Charles River Associates determined four states (Indiana, Maine, North Dakota, and Tennessee) are estimated to save a combined \$58.6 million annually through reduced public expenditures (e.g., Medicaid, Temporary Assistance to Needy Families, and state benefit payment programs) and additional state income taxes received from workers who were able to return to work.<sup>8</sup>

### **Comparing Disability and Health Insurance Claim Determinations**

As noted, the changes to the current claims procedure rule suggested by DOL are taken primarily from regulations adopted by DOL (along with the Departments of Health and Human Services and the Treasury) applicable to health benefits as required by the ACA. As an initial matter, Congress could have chosen to include disability income insurance as part of the new ACA standards applicable to health claims, but clearly choose not to do so.

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<sup>6</sup> Some of the innovative programs offered by disability insurance carriers to assist workers are discussed in “Trends and Innovations in Disability Income Insurance,” AHIP Center for Policy and Research, January 2010, accessed at: <http://www.ahip.org/Innovations-in-Disability-Insurance/>

<sup>7</sup> “Private Disability Insurance and Return-to-Work Cost Savings to SSDI and Other Federal Programs,” David Babbel and Mark F. Meyer, Charles River Associates, September 2013, accessed at: <http://www.ahip.org/PrivateDIReturntoWork92013/>

<sup>8</sup> “The Benefits of Private Disability Income Protection Coverage to State Budgets: Overview and Details for Four States,” David Babbel and Mark F. Meyer, Charles River Associates, July 2015 accessed at: <http://www.ahip.org/PrivateDisability715/>

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AHIP supports disability income insurance claimants access to a full and fair claims review process, however, disability insurance is quite different from health insurance. Any standards adopted by DOL must be considered in the context of how disability benefits actually work and the differences between claims for health benefits and those for disability income insurance.

As a general matter, claims for health benefits are fully automated (i.e. submitted electronically by the health care provider to the insurer or third-party administrator (TPA)). The insurer or TPA is making a benefit determination based on fairly simple questions – is the benefit covered, is the health care provider in-network, are the proper contracted prices applied to the claim, and are there any prior authorization or medical management issues that need to be addressed. In the latter situations (which constitute a very small subset of claim reviews) the insurer or TPA relies on medical experts to compare the services or treatment against established health care guidelines and protocols (i.e., recommendations of the U.S. Preventive Services Task Force). As a result, insurers and TPAs process hundreds of thousands of benefit claims on a daily basis. The small number of health claims that are denied (generally, for medical necessity reasons) are most always resolved through an internal appeals process or by submitting the claim for review by an external and independent third-party.<sup>9</sup>

A review of a claim for disability income benefits typically requires more extensive consideration by the insurer or TPA of a complex set of issues including the nature and extent of the illness or injury that led to the disability, the potential length or permanency of the disability based on the individual's health status and on-going medical treatment options, and the impact of the condition on the claimant's ability to resume or continue working. This analysis requires not only a full medical review but also an assessment of factors such as the functional capacity of the individual relative to his or her job duties, the individual's job skills, and the individual's potential ability to return to work on a part or full time basis. The process used by insurers and TPAs to review disability insurance claims may involve multiple health care and occupational experts and extensive assessments of the claimant. As discussed above, one of the goals of disability insurance is to return the individual to work where feasible and, as a result, the assessment of a claimant's condition and prognoses is often on-going over the course of the term of coverage.

It is clear that the analysis of health care claims (which are generally focused on whether a treatment or service is a covered benefit and should be reimbursed) differs markedly from the analysis of disability income claims (which involve a determination of an individual's ability to perform meaningful work). These variances affect the process used by the insurers and TPAs to review claims and should be taken into consideration by DOL in developing standards for internal appeals.

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<sup>9</sup> The fact that health claims may be submitted to external review is a significant reason why most claims are not litigated in federal court.

## **Determining the Cost of the Proposed Rule**

As noted in the Preamble to the Proposed Rule, federal agencies are required by Executive Orders 12866 and 13563 to assess costs and benefits of rulemaking. This analysis not only assists the agency “to select regulatory approaches that maximize net benefits . . . .” (80 Fed. Reg. 72020), but also better informs regulated entities of the expected costs and operational changes needed to implement the new requirements. Additionally, because the provision of disability income insurance by group health plans is voluntary, the regulatory cost analysis gives employers an indication of whether the projected cost of the new requirements justifies offering of such coverage to their employees.

The DOL erroneously concludes that there will only be two significant cost drivers resulting from adoption of these new requirements - (a) the need to provide claimants with any new or additional evidence considered during the course of the internal appeal and (b) a requirement to provide notices of adverse benefit determination in a culturally and linguistically appropriate manner. AHIP believes this assessment falls short of the reality within which disability plans operate.

With respect to the requirement to provide claimants with new or additional evidence or rationales, DOL expects it will take insurer or TPA staff at an hourly labor rate of \$30 only *five minutes* to gather, review, copy, and mail the materials although no data is presented to support this contention. The DOL cost assumption is a gross oversimplification and does not take into account either the task of identifying the additional or new information or rationale and the consequences of providing the materials to claimants (i.e., that the mailing will trigger a response by the claimant).

In addition, as discussed in more detail below, the Proposed Rule requires the plan to provide the new or additional evidence or rationale sufficiently in advance of the appeal deadline to give claimants the opportunity to respond. That response may generate additional work or consideration by the plan which in turn must be given to the claimant (with another opportunity to respond). This potentially endless round of appeals, responses, and reconsiderations will result in additional costs for the insurer or TPA (e.g., the need to retain additional expert resources to process appeals). These additional costs are not captured in DOL’s analysis.

Regarding the new language standards, DOL estimates specific costs for provision of oral language services (e.g., interpretation) and believes material, printing, and postage costs will total \$2.50 per mailing (although the DOL “assumes” most communications between insurers/TPAs and claimants will be electronic). As with the “new evidence” standard, there is no supporting data for the language standards cost determination other than a statement in the Preamble that similar estimates were used in connection with the ACA claims rule. In fact, it

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may be likely that due to privacy concerns on the part of plans, TPAs, insurers, and claimants, that most communication will continue to be provided by paper and through the U.S. mail and not by electronic means.

Also missing from the DOL cost determination is any analysis of the potential for increased litigation resulting from the adoption of the Proposed Rule – with additional costs imposed on plans and claimants. We believe there are two major areas of concern in this regard. First, the Proposed Rule establishes new conflict of interest standards for claim reviewers, including a requirement (as discussed in the Preamble to the Proposed Rule) that plans “not be permitted to contract with a medical expert based on the expert’s reputation for outcomes in contested cases . . .” (80 Fed. Reg. 72016-72017). We agree that experts should be retained based on their qualifications, however, such a “reputational” standard will potentially lead to additional litigation (including costs associated with discovery) as claimants’ counsels assert that medical experts have a vaguely defined reputation for denying claims.

Additionally, the new requirement that claimants may immediately proceed to federal court (with *de novo* review by the court of the benefit claim) if the plan does not “strictly adhere” to the claims rule will result in more cases being filed in federal court and legal disputes over whether the plan’s failure to follow the rule was *de minimis* and not part of an overall pattern of rule violations. The Proposed Rule introduces a variety of subjective compliance standards that are ripe for dispute under the strict adherence standard, such as whether information is provided “as soon as possible” and “sufficiently in advance” of the deadline for deciding appeals.

As a result, claim adjudication expenses can be expected to rise, and DOL has not factored into its analysis the very significant costs associated with having to go to court. Under the current rules, unless there is a futility claim, the parties typically pay the expenses for a court proceeding only once (i.e., post final appeal) as a product of the administrative process. The Proposed Rule, due to the introduction of the strict adherence standard and the *de minimis* exception procedures into the administrative process, would materially increase costs due to the amount of times plans and claimants are brought before a court during the life of a single claim.

DOL has not met the requirements for economic reviews of proposed rules as set out in Executive Orders 12866 and 13563 and has ignored the significant cost burdens that will be placed on plans and claimants. We strongly urge DOL to further examine the economic impacts of the changes being considered in order to assist in an appropriate agency determination of the regulatory costs and benefits and to assist insurers, TPAs, and employers with their responsibilities under ERISA.

## Comments and Recommendations on the Proposed Rule

Underpinning the Proposed Rule is DOL's apparent belief that a substantial (and growing) number of claimants are being unjustly denied disability income insurance benefits. That reasoning is stated as follows in the Preamble to the Proposed Rule:

Even though fewer private-sector employees participate in disability plans than in other types of plans, disability cases dominate the ERISA litigation landscape today. An aging American workforce may likely be a contributing factor to the significant volume of disability cases. Aging workers initiate more disability claims, as the prevalence of disability increases with age. And as a result, insurers and plans looking to contain disability benefit costs are often motivated to aggressively dispute disability claims.

(80 Fed. Reg. 72016, footnotes omitted).

There are several problems with the analysis presented by DOL. First, data indicates that the number of individuals filing disability claims has actually decreased over the past few years. The total number of both SSDI applications and awards has decreased since 2010<sup>10</sup> and the number of individuals receiving long-term disability insurance payments has also decreased.<sup>11</sup> While these declines are arguably due primarily to economic factors, there is no direct evidence that a "significant volume of disability cases" can be expected in the near future.<sup>12</sup>

In addition, the fact that a high percentage of ERISA claims filed in federal court are for long-term disability benefits (62 percent for long-term disability claims vs. 17.4 percent for health claims according to the study cited by DOL)<sup>13</sup>, this number is more likely the result of the complex nature of disability claim determinations as compared to most claims for health benefits, as discussed above. It should be noted that only a very small percentage of disability insurance claims ultimately reach the courts. The DOL-referenced study estimates 62 percent of ERISA cases in federal courts are for long-term disability benefits, while the most recent data from the Administrator of the United States Courts indicates that 7,191 ERISA cases were filed in 2014 (a number which has been

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<sup>10</sup> "Disabled Worker Beneficiary Statistics by Calendar Year, Quarter, and Month," U.S. Social Security Administration, Selected Data from Social Security's Disability Program, accessed at: <https://www.ssa.gov/OACT/STATS/dibStat.html>

<sup>11</sup> "2014 Long Term Disability Claims Review," *op cit*.

<sup>12</sup> In fact, the cost and complexity of the new standards proposed by DOL may result in fewer employers offering disability income insurance.

<sup>13</sup> "ERISA Benefits Litigation: An Empirical Picture," Sean M. Anderson, ABA J. Lab. & Emp. L.J., Fall 2012

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decreasing since 2010).<sup>14</sup> Applying the 62 percent estimate, it can be derived that 4,458 of these federal court filings were related to long-term disability benefits. Compared to the total number of long-term disability benefit claims that are expected to be filed annually (616,000 according to the DOL's cost analysis in the Preamble to the Final Rule<sup>15</sup>), the percentage of actual court filings is fairly miniscule (0.7 percent). While these cases are important to the claimants and group disability benefits plans engaged in litigation, they hardly represent a significant number of individuals who are facing barriers in resolving claim denials.

Finally, the DOL has presented no evidence to conclude that insurers or TPAs are aggressively disputing disability claims. In fact, the 0.7 percent court filing rate alone belies that assertion. It is in the best interest of insurers and TPAs and the group disability benefits plans they represent to quickly and fairly resolve disability benefit claims rather than "aggressively" denying claims and engaging in litigation. Employers have a wide choice of insurers and TPAs from which to choose and good claim servicing is likely a material part of any employer's selection process. Insurers and TPAs can (and do) control costs more efficiently by ensuring a claim is appropriately reviewed after the initial request, resolving any follow-up appeals if the benefit is denied, and working with the claimant to get them back to work if possible.

#### *Ensuring the Independence and Impartiality of Claim Reviewers*

The Proposed Rule establishes standards for the qualifications of individuals making decisions with respect to claims and appeals. Specifically, the plan must "ensure the independence and impartiality of the persons involved in making the decision." As a result, "decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support the denial of benefits." (Proposed §2560.503-1(b)(7)).

The Preamble to the Proposed Rule notes that, "a plan would not be permitted to provide bonuses based on the number of denials made by a claims adjudicator," and "would not be permitted to contract with a medical expert based on the expert's reputation for outcomes in contested cases, rather than based on the expert's professional qualifications." (80 Fed. Reg. 72016-72017).

AHIP agrees group disability plans must ensure that anyone making a decision with respect to a claim is acting in a responsible, knowledgeable, and impartial manner and is making decisions

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<sup>14</sup> "Table C-2A U.S. District Courts – Civil Cases Commenced, by Nature of Suit, During the 12-Month Periods Ending September 30, 2009 Through 2014," U.S. Courts, accessed at: <http://www.uscourts.gov/statistics-reports>

<sup>15</sup> "Table 2 – Fair and Full Review Burden," 80 Fed. Reg. 72023. This estimate by DOL reflects only those claims where additional evidence or rationale is generated and, as a result, the actual number of filed claims may be higher.

based only on the facts in hand. We support the language in the proposed rule for this standard. However, we are concerned with the suggestion in the Preamble that the adjudicator's "reputation for outcomes," absent any other factor (such as compensation based on decision results) is grounds for challenging the independence of the reviewer. For example, a medical expert may be selected based on his or her qualifications and compensated appropriately. That expert may subsequently have a high volume of denials due to the types of claims submitted and/or the lack of supporting evidence submitted by claimants. By imposing a vague "reputational" standard, DOL is inviting litigation with regard to the overall outcomes of all claims reviewed by a claims adjudicator or medical expert (which in turn opens the door for massive discovery requests), rather than a more appropriate challenge to the reviewer's qualifications or compensation.

**AHIP recommends that the standards in the Proposed Rule for the impartiality and independence of individuals reviewing claims be adopted. AHIP further recommends that DOL not adopt any standards that disqualify an adjudicator based solely on a "reputational standard" such as the volume of claim denials.**

*Providing Claimants with Information about Adverse Benefit Determinations*

The Proposed Rule states that notices to plan participants and beneficiaries of adverse benefit determinations (both the initial claim denial and any subsequent appeal decision) must include the following information:

- A discussion of the decision including the extent to which the plan did not follow or agree with the views presented by the claimant to the plan of: (a) health care professionals treating the claimant or (b) decisions of other benefit payers who granted a claimant's similar claim for benefits (including Social Security Administration (SSA) benefit determinations) and the basis for disagreeing with such views or decisions.
- The specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making the adverse determination or a statement that such information does not exist.
- A statement that the claimant may receive, on request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the benefit claim.<sup>16</sup>

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<sup>16</sup> Under the current claims rule applicable to disability benefits a document or other information is relevant" if: (a) it was relied upon in making the determination; (b) was submitted, considered, or generated in the course of making the determination; or (c) constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis (*see*: 29 CFR §2560.503-1(m)(8)).

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(Proposed §2560.503-1(g)(1)(vii) and (j)(6)).

We agree a claimant needs sufficient information about why his or her claim was denied under the governing disability income plan. There are, however, several concerns raised by the new requirements proposed by DOL.

First, a claims adjudicator takes into account a multitude of factors, such as various medical reviews, the claimant's functional capacity and job skills, and the claimant's ability to return to work on a part or full time basis. This decision process and the factors taken into consideration are very different from those considered by the individual's health care provider or even by other benefit payers.

A treating health care provider will focus on a patient's diagnosis and treatment plan while the disability claims adjudicator considers the long-term effect of the individual's condition on their ability to work. The claims adjudicators are not necessarily agreeing or disagreeing with medical findings by a treating health care provider, rather they are considering if the claimant's disease or illness significantly impairs their work skills. Comparing the two viewpoints does not provide claimants with any useful information with respect to a denial of benefits.

Even a determination that the individual is entitled to benefits under other coverage, such as worker's compensation or Social Security, is not dispositive of, and may not even be relevant to, an adjudicator's decision rendered under the governing disability income insurance policy or plan. For example, under rules related to SSDI, a disability is "the inability to do any substantial gainful activity by reason of any medical determinable physical or mental impairment which can be expected to result in death or which has lasted or is expected to last for a continuous period of not less than 12 months." (20 CFR §404.1505(a)). Disability for purposes of disability insurance is defined by the terms of the plan or policy and is typically related to the ability of the employee to perform the specific responsibilities of his or her current occupation or, longer-term, any other occupation for which they may qualify. A finding of disability by the SSA does not indicate that an individual is or is not disabled for purposes of a private disability insurance, many of which vary in their definitions of disability.

Claims adjudicators are trained to understand their own plan or policy requirements and apply those standards to claims in accordance with the internal rules, guidelines, policies, and procedures. The Proposed Rule puts disability income insurance claims adjudicators in the untenable position of having to be aware of and the ability to interpret the legal standards and evidence considered by other benefit payers.<sup>17</sup>

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<sup>17</sup> For example, will insurers and TPAs be expected to be experts in the worker's compensation standards applicable in all U.S. states and territories?

In addition, we are concerned about the proposed requirement that a claims adjudicator must inform claimants if “internal rules, guidelines, protocols, standards, or other similar criteria of the plan relied upon in making the adverse determination” do *not* exist. The rules are clear that such information must be provided if requested and the plan will comply with such requests. It does not make sense, therefore, to have plans respond negatively since they will make the information available as needed.

**AHIP supports adoption of the proposed standards for disclosures of information about adverse benefit determinations with two exceptions: (a) claims adjudicators should not be required to specifically address whether they disagree with views presented by the claimant’s treating health care professional or decisions of other benefit payers and (b) claims adjudicators should not be required to state that internal rules, guidelines, protocols or other information “does not exist.”**

*Providing Notices in a Culturally and Linguistically Appropriate Manner*

The Proposed Rule adopts new standards for providing notices and communicating with individuals who have limited English language proficiency. Plans must provide oral language services (e.g., telephone customer hotlines) that support their institution’s ability to respond to questions in any applicable non-English language. Plans must also provide assistance with filing claims and appeals in any applicable non-English language. In addition, notices must be provided on request in any applicable non-English language. Plans must also include in the English versions of all notices a statement in applicable non-English languages indicating how to access language services. The “applicable non-English language” statement is required if the notice is sent to any county in which 10 percent or more of the residential population is literate only in the same non-English language. (Proposed §2560.503-1(p)).

AHIP supports this change to the current rules. As discussed below, however, many insurers and TPAs responsible for disability insurance administration do not currently have systems in place to provide oral translation services and the necessary language disclosures on notices and other materials that are sent to claimants. The Preamble to the Proposed Rule indicates that since most health insurers already comply with language requirements for health claims, there will be minimal compliance costs. In fact, many insurers and TPAs responsible for disability income insurance claims do not have similar capability, even if that insurer or TPA is affiliated with a health insurer that does. For this reason, we believe the implementation date for the rule must provide covered entities a reasonable time to come into compliance.

**AHIP recommends DOL adopt the proposed requirements for providing notices to claimants in a culturally and linguistically appropriate manner. AHIP further**

**recommends that DOL give covered entities reasonable time to comply, given the operational changes and costs associated with these new standards.**

*Appeals of Adverse Benefit Determinations*

The Proposed Rule requires plans to provide claimants, free of charge, with any new or additional evidence or rationale generated or considered by the plan in connection with the claim. This information “must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided . . .” (Proposed §2560.503-1(h)(4)(i) and (ii)). Claimants must be given a reasonable opportunity to respond to any new or additional evidence or rationale in advance of the time limits for making plan decisions. The Preamble to the Proposed Rule explains the process as follows:

As an example of how these new provisions would work, assume the plan denies a claim at the initial stage based on a medical report generated by the plan administrator. Also assume the claimant appeals the adverse benefit determination and, during the 45-day period the plan has to make its decision on appeal, the plan administrator causes a new medical report to be generated by a medical specialist who was not involved with developing the first medical report. The proposal would require the plan to automatically furnish to the claimant any new evidence in the second report. The plan would have to furnish the new evidence to the claimant before the expiration of the 45-day period. The evidence would have to be furnished as soon as possible and sufficiently in advance of the applicable deadline (including an extension if available) in order to give the claimant a reasonable opportunity to respond to the new evidence. The plan would be required to consider any response from the claimant. If the claimant’s response happened to cause the plan to generate a third medical report containing new evidence, the plan would have to automatically furnish to the claimant any new evidence in the third report. The new evidence would have to be furnished as soon as possible and sufficiently in advance of the applicable deadline to allow the claimant a reasonable opportunity to respond to the new evidence in the third report.

(80 Fed. Reg. 72017).

The Proposed Rule does not address how plans should react if the review process cannot be completed within in the 45-day deadline for making appeal decisions. The Preamble does note that plans for disability benefits may request an extension of time to reach a decision on appeal “due to a claimant’s failure to submit information necessary to decide a claim.” (29 CFR §2560.503-1(i)(4)). The period of time to make a determination is tolled starting with the date on which the claimant is notified that additional information is required. The Preamble asks if

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special tolling rules are needed and whether the tolling rule adopted for group health plan claim appeals should be used. That rule provides as follows:

(I)f the new or additional evidence is received so late that it would be impossible to provide it to the claimant in time for the claimant to have a reasonable opportunity to respond, the period for providing a notice of final internal adverse benefit determination is tolled until such time as the claimant has a reasonable opportunity to respond. After the claimant responds, or has a reasonable opportunity to respond but fails to do so, the plan administrator shall notify the claimant of the plan's benefit determination as soon as a plan acting in a reasonable and prompt fashion can provide the notice, taking into account the medical exigencies.

(29 CFR §2590.715-2719(b)(2)(ii)(C)(2)).

AHIP supports procedures allowing claimants access to all information necessary to effectively challenge a claim denial that they believe to be incorrect. However, we have concerns with the new process set out in the Proposed Rule which we believe will significantly prolong the determination and appeals process, increase the potential for litigation, and significantly expand compliance costs.

Courts have acknowledged the need for speedy and efficient resolution of disability claims. This issue was addressed by the federal appellate court in *Metzger v. Unum Life Insurance Company*, 470 F. 3d 1161 (10<sup>th</sup> Cir. 2007):

Permitting a claimant to receive and rebut medical opinion reports generated in the course of an administrative appeal—even when those reports contain no new factual information and deny benefits on the same basis as the initial decision—would set up an unnecessary cycle of submissions, review, re-submission, and re-review. This would undoubtedly prolong the appeal process, which under the regulations, should normally be completed within 45 days. Moreover, such repeating cycles of review within a single appeal would unnecessarily increase cost of appeals.

470 F. 3d 1161, 1166-1167 (internal citations omitted). *See also: Pettaway v. Teachers Insurance and Annuity Association of America*, 644 F. 3d 427 (DC Cir. 2011); *Midgett v. Washington Group International Long Term Disability Plan*, 561 F. 3d 887 (8<sup>th</sup> Cir. 2009); and *Glazer v. Reliance Standard Life Insurance Company*, 524 F. 3d 1241 (11<sup>th</sup> Cir. 2008).

The point of these decisions is clear – claimants and plans need an orderly process that provides finality and clear decision making. An endless round of reviews is also contrary to the policy

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reasons behind the original claims rules issued by DOL in 2000 which recommended a process that “will ensure that benefit claimants, at least in ERISA covered plans, are provided faster, fuller, and fairer decisions on their benefit claims.” (65 Fed. Reg. 70249).

In addition, the new requirements contemplated by the Proposed Rule are simply not necessary. During an appeal of a denial of benefits, the plan administrator reconsiders its original decision based on information provided by the claimant. The plan administrator may also, as part of that review, have additional medical or other reviews (e.g., occupational assessments) of the claimant. If material from these additional reviews support the original decision, it is unnecessary for the claimant to respond. Nor should the Proposed Rule be imposed on a plan that has an established process for secondary level of internal appeals. Contrary to the Proposed Rule, which could very well result in an endless loop of document production, a secondary level of internal appeals would provide claimants with the information that they need to contest the denial of income benefits.

**AHIP recommends that DOL not establish standards for claimants to respond to new reports, rationales or other materials generated by the plan during the course of an appeal prior to the end of the 45 day time period for the plan to make a decision, particularly with respect to a plan that already has in place an established process for a secondary internal level of appeals.**

#### *Failure to Establish or Follow Reasonable Procedures*

If a plan fails to “strictly adhere” to the standards in the claims procedure rules, the claimant is deemed to have exhausted the administrative remedies under the plan and may pursue any available remedies under ERISA Section 502(a). In addition, “(i)f a claimant chooses to pursue remedies under section 502(a) of ERISA under such circumstances, the claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary.” (Proposed §2560.503-1(1)(2)(i)). As stated in the Preamble to the Proposed Rule, “rather than giving special deference to the plan, the reviewing court should review the dispute *de novo*.” (80 Fed. Reg. 72018).

Administrative remedies are not deemed exhausted under a plan if the failure to follow the claims rule is, “based on *de minimis* violations that do not cause, and are not likely to cause prejudice or harm to the claimant . . . .” The plan must demonstrate that the violation was for good cause or due to matters beyond the plan’s control and that the violation “occurred in the context of an ongoing, good faith exchange of information between the plan and the claimant.” (Proposed §2560.503-1(1)(2)(ii)). If requested, the plan must provide claimants with a written explanation for asserting that the violation did not cause the administrative remedies available under the plan to be exhausted. If a court rejects a claimant’s request for immediate review of a claim under this provision, the claim is considered refilled on appeal upon the plan’s receipt of

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the court's decision. After a reasonable period of time, the plan must provide claimants with a notice of the resubmission of their appeal.

These new requirements suggested by DOL will unnecessarily preempt the procedures established by plans to resolve disputed claims and significantly increase litigation and compliance costs. Claimants will be encouraged to immediately file proceedings in federal court if they believe the plan has in any manner – however insignificant, non-prejudicial or technical– failed to follow the claims rules, especially if the court's review will be *dev novo*. Under the Proposed Rule, it appears that any claimant can lodge *any unfounded allegation* that a plan is not strictly adhering to *any part* of the claim procedure, including any of the subjective standards set out by the rule. For example, a simple allegation that new information was not furnished “as soon as possible” or “sufficiently in advance” of the deadline for decision making would require the plan to engage in the process of a written explanation.

Further, what if the plan misses a notice or other deadline by a day or two, is this sufficient cause to argue a failure to follow the rules? Will courts now contend with disputes between plans and claimants whether a violation was *de minimis* or part of an ongoing good faith exchange of information? If the “failure” occurs near the end of the plan's review process, should claimants be permitted to essentially re-litigate all issues by claiming the plan did not strictly follow the rules and requesting a *de novo* review? The time and expense both for plans, claimants, and the courts seems unjustified when viewed against the assumed benefit.

Under the existing rule, claimants are entitled to challenge the plans procedures and may request *de novo* review, but have done so together with a full and complete record ripe for the court to adjudicate. *See: Massachusetts Mutual Life Insurance Co. v. Russell*, 473 U.S. 134 (S. Ct. 1985); *Nichols v. Prudential Insurance Company*, 406 F. 3d 98 (2<sup>nd</sup> Cir. 2005); *Fallick v. Nationwide Mutual Insurance Company*, 162 F. 3d 410 (6<sup>th</sup> Cir. 1998); and *Curry v. Contract Fabricators, Inc.*, 891 F. 2d 842 (11<sup>th</sup> Cir. 1990). Under the Proposed Rule, however, even a completely baseless claim of procedural violation could be filed in court, only to have the court send the dispute back to the administrative process if the court determines the plan acted appropriately. Even if the claimant demonstrates a procedural error by the plan, there may be a less than fully-developed claim record and the court may choose to remand the matter back to the administrator, where the process starts all over again.

The ultimate goal of the claims rule is to focus claimants and plans on the real issue – is the claimant disabled and is he or she able to work. Shifting that focus to disagreements over whether the plan has failed in some minor way to follow all of the necessary steps laid out in the rule distracts from that goal.

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**AHIP recommends that DOL adopt rules encouraging claimants to resolve disputes through the internal claims and appeals process, rather than inviting legal disputes over technical and non-prejudicial violations of the rule.**

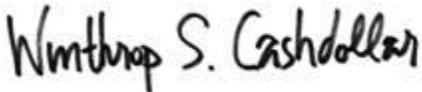
*Effective Date*

The Preamble to the Proposed Rule indicates the final rule will be effective 60 days after publication in the *Federal Register* (80 Fed. Reg. 72020). Given the significant and extensive changes contemplated, plan sponsors, insurers, and TPAs will need sufficient time to make the necessary operational and operational changes to implement the new standards. For example, the requirement to add language translation services for customer call centers, add appropriate language tag-lines to notices, and (if necessary) translate documents into applicable non-English languages, will take time (e.g., adding and training support staff, ensuring translation services, upgrading information technology systems, negotiating and contracting with outside vendors). At a minimum, the new requirements, once finalized, should be effective for plan years beginning 12 months after the date the final rule is published.

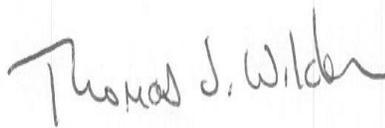
**AHIP recommends that the effective date of any new standards adopted by DOL is for plan years beginning 12 months after the date of publication of the final rule.**

AHIP and its members appreciate the opportunity to provide feedback regarding the Proposed Rule and we look forward to working with the DOL on these important issues.

Sincerely,



Winthrop S. Cashdollar  
Executive Director, Product Policy



Thomas J. Wilder  
Senior Counsel