

**America's Health
Insurance Plans**

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December 11, 2017

Jeanne Wilson
Acting Assistant Secretary of Labor
Employee Benefits Security Administration
Room N-5655
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

Submitted electronically via e-ORI@dol.gov

Re: Claims Procedure for Plans Providing Disability Benefits; Merits of Rescinding, Modifying, or Retaining Final Rule (RIN 1210-AB39)

Dear Acting Assistant Secretary Wilson:

America's Health Insurance Plans (AHIP) appreciates the opportunity to offer comments providing data and information bearing on the merits of rescinding, modifying, or retaining the U.S. Department of Labor (Department) final rule (Rule) amending disability claim procedures (81 Fed Reg. 92316 (Dec. 16, 2016)) under the Employee Retirement Income Security Act of 1974 (ERISA). AHIP is the national association whose members provide coverage for health care and related services, including disability income protection coverage. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access, and well-being for consumers.

AHIP is pleased that the Department has delayed the applicability date of the Rule and commend the Department for undertaking an examination of the Rule's merits in light of additional data and information. **We strongly recommend that, upon receipt and consideration of additional data and information, the Department significantly modify the Rule and further extend its applicability date beyond April 1, 2018.**

As noted in previous correspondence, AHIP has serious concerns regarding the Rule. While intended to improve the claim review process and consumer experience for private disability income insurance claimants, if allowed to take effect as currently written, the Rule would instead drive up the cost of private disability income protection without providing significant real benefit to working Americans. This would impose counterproductive, unnecessary, and increased costs on consumers and reduce consumer access to disability income protection. Our concerns include:

- **Increased Litigation and Litigation Costs:** The Rule’s “Strict Adherence” and “Deemed Exhaustion” provisions at 29 CFR Part 2560.503-1(1)(1) and (2) would lead to increased litigation, incomplete and inadequate administrative records, unnecessary additional legal costs, and increased burdens upon the federal courts. We recommend that these provisions be removed from the final Rule.
- **Delayed Dispute Resolution:** The Rule’s provisions granting claimants new rights to review and respond to “new” or “additional” evidence at 29 CFR Part 2560.503-1(h)(4)(i) and (ii) would raise costs and delay claim resolution by inviting protracted back and forth exchanges between claimants and plan administrators. We recommend that these provisions be removed from the final Rule.
- **Greater Financial Risk to Families and Costs to Government:** By raising the cost of private disability income protection, the Rule would drive down access to coverage; expose more working Americans to the financial risk of disabling illness or injury; and force more families to rely on public disability and income support programs, such as Medicare and Medicaid.

I. Information Germane to the Merits of the Rule

Cost of Group Disability Income Protection

Today the group market offers affordable, robust disability income protection to working Americans. Employer-sponsored disability insurance plans cover 40 percent of American workers in private industry against the financial risk of short-term disability, and 32 percent of American workers in private industry against the financial risk of long-term disability.¹ Having coverage available to a significant proportion of working Americans is a direct result of its affordability. For new policies sold in the United States during 2015 and 2016, average premium per life for short-term disability income protection was \$183.² Average premium per life for group long-term disability protection was \$222.³

As discussed above, the specific implementation cost of provisions of the Rule that are of concern would lead to increases in the cost of disability income protection coverage for consumers. We are concerned that these increased costs will lead to reduced protections for working Americans against the risk of disabling illness or injury. Changes to regulatory requirements that require plan administrators to add steps to the claim adjudication process, hire

¹ U.S. Department of Labor, Bureau of Labor Statistics, National Compensation Survey, Insurance Benefits: Access, Participation, and Take-Up Rates, March 2017

² Summary of Key Results from the 2016 U.S. Group Disability Market Survey, Milliman, May 2017

³ *Ibid*

December 11, 2017

Page 3

additional staff, and/or increase liability will inevitably raise the cost of disability income protection coverage. As detailed in comments AHIP submitted in response to the notice of proposed rulemaking that was published on November 18, 2015, it is our view that the Department very seriously underestimated the additional costs that the Rule would impose.⁴

The cost of disability income protection varies according to the risk that is insured. For group disability income protection, risks and costs vary by the industry or business of the employer/policyholder and by the demographic characteristics of the insured group – including age and compensation. The group disability premium an employer/policyholder pays is often based extensively on the group's experience, that is, the group's recent history of employees claiming disability income benefits.

Impact of Cost Increases on Number of Working Americans with Disability Income Protection
AHIP and other stakeholders commissioned an analysis based on surveys of working Americans and benefit managers to collect data regarding the impact of increases in the cost of coverage on the number of working Americans who have disability income protection coverage. The analysis indicates that cost increases do materially affect access to coverage.⁵

The impact of an increase in the cost of coverage does vary with employers of different sizes, in different industries, etc. As a rough estimate, if the Rule increased the cost of coverage by as much as the industry estimates of 5% to 8%⁶, nearly one million working Americans who would otherwise have long-term disability income protection would lack it.⁷

This estimate is conservative for two reasons. First, benefit managers would not consider disability income protection in isolation. Rather, benefit managers would generally need to consider disability income protection in the context of an employee benefit package that includes other benefits, most of which are a higher priority for employers and employees and some of which may be increasing in cost. Second, many employers are likely to be induced, by an increase in the cost of disability income protection and/or by other employee benefit cost pressures, to switch from employer-paid to employee-paid disability income plans. Employee participation in employer-paid disability income plans approaches 100 percent. Employee

⁴ AHIP Letter to DOL. Available at regulations.gov at: <https://www.regulations.gov/document?D=EBSA-2015-0017-0275>. January 19, 2016.

⁵ Price Elasticity of Demand for Long Term Disability Insurance, Isobar, December 2017. Available for download at: <https://data.ahip.org/?linkid=KZi4zr6VWWUA4Ed/zd0Jl6eX3dq5tAix8YDODS6ncAGbVD1eBxRJJQ/>.

⁶ 82 Fed. Reg. 47411

⁷ This estimate is derived by multiplying the price elasticity of demand for long-term disability income protection, as calculated from the results of a survey of benefit managers regarding their sensitivity to price increases for employer-paid disability coverage (-0.3), by an 8 percent increase in the cost of coverage in an employer-sponsored insurance market covering 40 million Americans working in private industry.

December 11, 2017

Page 4

participation in employee-paid plans is typically under 50% - and often in the range of 20 – 25%.

Our analysis shows increases in the cost of coverage would have the most significant impact on financially vulnerable working Americans. A survey of working Americans indicates that individuals in group long-term disability income protection plans under which they pay for the coverage themselves are sensitive to the cost of coverage.⁸ The survey also shows that working Americans in the lower income quartiles are more price sensitive than working Americans who earn more. Working Americans in the lowest income quartile (earning less than \$30,000 per year) are the most vulnerable to the financial risk of work disability and, as shown by Department of Labor data, the least likely to have private disability income protection.⁹ Increases in the cost of long-term disability income protection would have a significant negative impact on coverage under employee-paid plans, and a significant impact on the prospects for the expansion of coverage to more working Americans under such plans.

Increased Burden on Federal and State Programs

Regulatory changes that increase the cost of coverage and reduce the number of working Americans with private disability income protection will increase the burden on public programs that provide assistance to persons with disabilities. Disability income protection replaces income lost because of disabling injury or illness and helps 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. These key features of disability income protection decrease costs that persons with work disabilities would otherwise place on federal and state public assistance programs.

Two analyses by Charles River Associates for AHIP examined the positive impact of disability income protection on public programs. One analysis considered the benefits to the federal treasury resulting from the reduction of Social Security Disability Insurance (SSDI) payments and other federal assistance (e.g., Medicare, Medicaid, and the Supplemental Nutritional Assistance Program) because the private disability income claimants either did not need the federal benefits or were able to return to work sooner. According to the analysis, the currently in-force private long-term disability income protection coverage is 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).¹⁰ Similar benefits were found at the state level. A follow-on analysis by Charles River Associates determined that four selected states (Indiana, Maine, North Dakota, and Tennessee) are estimated to save a combined \$58.6 million

⁸ Price Elasticity of Demand for Long Term Disability Insurance, Isobar, December 2017

⁹ U.S. Department of Labor, Bureau of Labor Statistics, National Compensation Survey, Insurance Benefits: Access, Participation, and Take-Up Rates, March 2017

¹⁰ Private Disability Insurance and Return-to-Work Cost Savings to SSDI and Other Federal Programs, David Babbal and Mark F. Meyer, Charles River Associates, September 2013

December 11, 2017

Page 5

annually through reduced public expenditures (e.g., Medicaid, Temporary Assistance to Needy Families, and state benefit payment programs) and additional state income taxes received at current levels of disability income protection coverage.¹¹ By driving down access to disability income protection, the Rule would drive up costs to federal and state public assistance programs.

Increased Burdens on Federal Courts

The Rule's provisions incentivizing claimants to litigate claim disputes would greatly add to the burdens and backlogs facing the federal courts. The Rule provides, at the claimant's option, for a short-cut to the federal courts and to *de novo* court review if a plan does not "strictly adhere" to its provisions. For many years, federal courts have employed a "substantial compliance" standard which, appropriately, allows room for inconsequential and non-material errors within the efficient administrative process envisioned under ERISA. Unfortunately, the effect of the Rule as promulgated would be to give claimants and claimants' attorneys inappropriate incentives to allege failure of strict adherence even when no such failure occurs or when lack of strict adherence is trivial. As a result, federal court dockets would become even more burdened than they already are. Claimants who short-cut the administrative process will bring to court less developed and incomplete administrative records.

Federal courts are already seriously overburdened. During the past five years, while the number of federal judges has remained stable, the average time for civil cases pending in the District Courts has risen from 6.8 months (as of mid-year 2012) to 10.4 months (as of mid-year 2017).¹² As of June 30, 2017, more than 17 percent of District Court civil cases had been pending for more than three years.

II. Recommendations for Modifications to the Rule

Appeals of Adverse Benefit Determinations (§2560.503-1(h)(4)(i) and (ii))

- **We recommend that the Department modify the Rule by eliminating new requirements for claimants to respond to new reports, rationales or other materials generated by the plan. This is particularly important with respect to plans that already have in place an established process for a secondary internal level of appeals.**

¹¹The 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

¹² Administrative Office of the U.S. Courts, United States District Courts - National Judicial Caseload Profile, as of June 30, 2017

December 11, 2017

Page 6

The Rule would require 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... .” 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.

We support 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 Rule, which would significantly prolong the determination and appeals process, increase the potential for litigation, and increase compliance costs.

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 frequently and extensively 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.

In addition, these new requirements are unnecessary. During an appeal of a denial of benefits, the plan administrator reconsiders the 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 such requirements be imposed on a plan that has an established process for secondary level of internal appeals. Contrary to the Rule, which could result in an endless loop of document production, a secondary level of internal appeals provides claimants with the information that they need to contest the denial of income benefits.

Failure to Establish or Follow Reasonable Procedures (29 CFR §2560.503-1(l)(1) and (2))

- **We recommend that the Department modify the Rule to return to a focus on 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.**

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

December 11, 2017

Page 7

deemed denied on review without the exercise of discretion by an appropriate fiduciary” (see 29 CFR §2560.503-1(1)(1) and (2)).

Administrative remedies are not deemed exhausted under a plan if the failure to follow the 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” (see 29 CFR §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 refiled on appeal upon the plan’s receipt of 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 would unnecessarily preempt the procedures established by plans to resolve disputed claims and significantly increase litigation and compliance costs. Claimants will be encouraged to file proceedings immediately in federal court if they believe the plan has in any manner – however insignificant, non-prejudicial or technical– failed to follow the Rule, especially if the court’s review will be *de novo*. Under the Rule, it appears that any claimant can lodge *any unfounded allegation* that a plan is not strictly adhering to *any part* of the Rule, 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.

The regulatory approach should emphasize the key question: 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 steps laid out in the rule distracts from that goal.

If the Rule becomes applicable as currently written, it would raise the costs of group disability income protection significantly. This, in turn, would result in many fewer working Americans with disability income protection. This would expose working Americans and their families to the financial risk of disabling illness or injury and increase the burden on public programs that assist persons with disabilities. These costs outweigh the purported benefits of the Rule. AHIP strongly recommends that the Department significantly modify the Rule and allow ample time for stakeholders to come into compliance with a revised Rule.

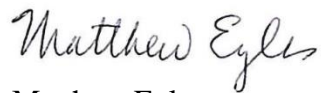
AHIP and our disability income plan members welcome the opportunity to continue to work with the Department to help inform the re-examination of the Rule. To allow adequate time for

December 11, 2017

Page 8

consideration of additional data and information bearing on the merits of the Rule, and a thorough re-examination, revision, and implementation, we recommend that the Department delay applicability of the Rule well beyond April 1, 2018 to fully accommodate each of these crucial steps.

Sincerely,

A handwritten signature in cursive script that reads "Matthew Eyles".

Matthew Eyles

Senior Executive Vice President and Chief Operating Officer