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Claims Procedure for Plans Providing Disability Benefits

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Claims Procedure for Plans Providing Disability Benefits

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General Comment

See attached file(s)From my experience as a paralegal working for an attorney in the ERISA arena I find several advantageous points
of the proposed changes such as:

1. A plan not being permitted to provide bonuses based on the number of adverse decisions of disability claims and/or appeals.

2. The claimant having an opportunity to respond to any new or adverse evidence the plan has developed while reviewing a claim for disability
benefits prior to a claims decision being made. The claimant should have the right to defend their rights for a full and fair review prior
to a claims decision.

3. That any third-party medical report be provided to the claimant during the the plan's 45-day period the plan has to make its decision
on appeal and not having the right to extend the 45 to 90 day review period in which to acquire that third-party medical report from a
medical provider who has not examined the claimant and not allowing the claimant a sufficient

opportunity in which to respond to the
third-party medical report.

4. That safeguards be put into place requiring adverse benefit decisions be offered in a culturally and linguistically appropriate manner
manner where appropriate.

Attachments

ERISA Decisions

a plan would not be permitted to provide bonuses based on the number of denials made by a claims adjudicator. Similarly, a plan would not be permitted to contract with a medical expert based on the expert's reputationfor outcomes in contested cases, rather than based on the expert's professional qualifications. These added criteria address practices and behavior which, in the context of disability benefits, the Department finds difficult to reconcile with the “full and fair review” guarantee in section 503 of ERISA and which are questionable under ERISA's basic fiduciary standards.

The proposal would add criteria to ensure a full and fair review of denied disability claims by explicitly providing that claimants have a right to review and respond to new evidence or rationales developed by the plan during the pendency of the appeal, as opposed merely to having a right to such information on request only after the claim has already been denied on appeal, as some courts have held under the Section 503 Regulation. Specifically, the proposal provides that prior to a plan's decision on appeal, a disability benefit claimant must be provided, free of charge, with any new or additional evidence considered, relied upon, or generated by (or at the direction of) the plan in connection with the claim, as well as any new or additional rationale for a denial, and a reasonable opportunity for the claimant to respond to such new or additional evidence or rationale. *See* paragraph (h)(4)(i)-(iii) of the proposal. Although these important protections are direct imports from the 2719 Final Rule, they would correct procedural problems evidenced in the litigation even predating the ACA. (13) It is the view of the Department that claimants are deprived of a full and fair review, as required by section 503 of ERISA, when they are prevented from responding at the administrative stage level to evidence and rationales. (14) Accordingly, adding these provisions to the

Section 503 Regulation would explicitly address this problem and redress the procedural wrongs evidenced in the litigation under the current regulation.

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.

The proposal contains safeguards for individuals who are not fluent in English. The safeguards would require that adverse benefit determinations with respect to disability benefits be provided in a culturally and linguistically appropriate manner in certain situations. The safeguards include standards that illustrate what would be considered “culturally and linguistically appropriate” in these situations. The safeguards and standards are incorporated directly from the 2719 Final Rule and reflect public comment on that rule. The relevant standards are contained in paragraph (p) of the proposal.

Under the proposed safeguards, if a claimant's address is in a county where 10 percent or more of the population residing in that county, as determined based on American Community Survey (ACS) data published by the United States Census Bureau, are literate only in the same non-English language, notices of adverse benefit determinations to the claimant would have to include a

prominent one-sentence statement in the relevant non-English language about the availability of language services. (18) In addition, the plan would be required to provide a customer assistance process (such as a telephone hotline) with oral language services in the non-English language and provide written notices in the non-English language upon request. Oral language services includes answering questions in any applicable non-English language and providing assistance with filing claims and appeals in any applicable non-English language.