National Business Group on Health®

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Creative Health Benefits Solutions for Today, Strong Policy for Tomorrow

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Submitted electronically via: www.regulations.gov

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: RIN 1210-AB39 – Claims Procedure Regulation Amendment for Plans Providing Disability Benefits

Dear Sir or Madam:

The National Business Group on Health is pleased to respond to the Department of Labor's proposed amendments to claims procedure regulations for plans providing disability benefits under ERISA.

The National Business Group on Health represents 427 primarily large employers, including 70 of the Fortune 100, who voluntarily provide group health plan coverage to over 55 million American employees, retirees, and their families. Our members employ and provide disability and health coverage for employees under a wide variety of work arrangements, including full-time, part-time, seasonal, and temporary. They also often operate multiple lines of business in multiple states and tailor employee work and benefit arrangements to the specific needs of each line of business.

National Business Group on Health members support the Department's efforts to protect plan participants' rights to adequate notice and full and fair reviews of disability claims. However, our members are deeply concerned that many of the Department's proposals will only increase participant confusion, plan costs, and litigation with little benefit to participants. We urge the Department, as it develops final regulations, to consider the following:

- Our members are at the forefront of developing comprehensive health and productivity strategies designed to improve workforce health and safety, improve and maintain productivity, and remain employers of choice. Our members do not focus narrowly on containing costs by aggressively disputing individual disability claims, as suggested by the Preamble to the notice of proposed rulemaking. They also must consider the costs of employees' time away from work and employee replacement costs, such as recruitment and training costs, when an employee is

not working due to a disability. Therefore, our members have a substantial incentive to design and administer benefit programs with the aims of improving employees' health, safety, and ability to return to work.

- To further these aims, final regulations should maintain plan sponsors' flexibility to establish plan terms and administer benefits accordingly. Maintaining or reducing plans' administrative and cost burdens also will permit plan sponsors to devote more resources toward maintaining and improving benefits for their employees.

- The current Section 503 Regulation already provides robust participant protections by, among other things, requiring plans to detail reasons for adverse benefit determinations, providing access to relevant records and information, and including a deemed exhaustion provision. Our members devote substantial administrative and financial resources to complying with these requirements and have found that current claims and appeals procedures provide ample opportunity for claimants to review relevant information and pursue appeals. The additional requirements in the notice of proposed rulemaking will only increase administrative and cost burdens without providing useful information or meaningful protections for participants.

We provide further discussion and recommendations below.

I. Disclosure Requirements

Final regulations should not include a requirement that adverse benefit determinations include the basis for disagreeing with any disability determination by the Social Security Administration (SSA), by a treating physician, or other third party disability payor, to the extent that the plan did not follow those determinations presented by the claimant.

As plan fiduciaries, our members have an obligation under ERISA to administer disability benefits in accordance with plan documents, including plans' definitions of "disability." Because plan terms are tailored to the specific needs, aims, and benefit offerings of our members' specific workforces, disability determinations for employer-sponsored plans can differ from those of the SSA, physicians, or other third parties who apply different definitions of disability and will not be familiar with plan documents and terms.

To comply with the Department's proposal, employer-sponsored plans will have to apply and interpret third parties' definitions of disability and medical assessments—a task that plans generally will not have sufficient information or expertise to complete. Furthermore, explaining the basis for disagreeing with a third party's disability determinations will substantially lengthen and complicate notices of adverse benefit determination. To ensure compliance, plans will likely feel compelled to provide highly detailed, technical explanations of how the facts of individual claims apply to both plan and third party disability definitions. Such detail is likely to cause confusion for

participants and increase plan costs without providing additional information that would assist a participant in evaluating his or her claim under the plan at issue.

The current Section 503 Regulation requires plans to notify participants of the specific reasons and plan provisions that form the basis for an adverse benefit determination—information sufficient for a claimant to determine the basis for the plan's decision and whether the claimant may wish to pursue an appeal. We therefore recommend that the Department maintain this rule and, in final regulations, eliminate the requirement that adverse benefit determinations include the basis for disagreeing with any disability determination by the SSA, treating physician, or other third party payor.

II. Right to Review and Respond to New Information

Final regulations should not include a requirement that, prior to a plans' decision on appeal, a disability benefit claimant 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.

As noted above, the current Section 503 Regulation requires plans to notify participants of the specific reasons and plan provisions that form the basis for an adverse benefit determination. Claimants also are entitled to receive internal rules, guidelines, protocols, or other similar criteria that plans rely upon in making adverse benefit determinations, free of charge upon request. We believe these procedures are sufficient for a claimant to determine the basis for a plan's decision and whether the claimant may wish to pursue an appeal.

This Department's proposal to provide new or additional evidence automatically during the pendency of an appeal could involve providing large amounts of additional information, with substantial administrative and cost burdens. This additional information would likely result in claimants receiving information that is confusing and not helpful in evaluating claims. For example, claim files may include sensitive medical information that is best reviewed with a primary care physician. Requiring plans to provide this information automatically could cause claimants confusion and may even interfere with ongoing treatment.

This proposal also raises significant privacy and security concerns. If plans are to provide this information—which may include sensitive medical information—automatically, they must rely on claimants' last available contact information. If plans rely on the last available contact information, they will not be able to ensure that the information is viewed only by claimants. Therefore, if final regulations include this rule, we recommend that the Department, in coordination with the Department of Health and Human Services, provide guidance on how plans can ensure that such disclosures do not result in a breach, as defined by HIPAA.

For the reasons above, we recommend that the Department eliminate the requirement plans automatically provide new or additional evidence considered, relied upon, or

generated by the plan in connection with a claim. If final regulations do include this rule, the regulations should, at minimum, define the types of information that plans must provide automatically and take into account the fact that plans and participants will need adequate time to engage in these procedures. We support adoption of a tolling rule that would toll the period for providing claims decisions until claimants respond and plans have an opportunity to review those responses. Our members are also concerned that the back-and-forth process involved with automatically providing information, claimant responses, and plan responses could extend far beyond the time frames under the current Section 503 Regulation. Therefore, we also recommend that final regulations include a rule stating that plans can establish a reasonable amount of time for claimants to respond to any new information, after which plans can proceed with their claims decisions.

III. Deemed Exhaustion of Claims and Appeals Processes

Final regulations should not amend the deemed exhaustion provision in the current Section 503 Regulation.

We support the Department's efforts to protect plan participants' rights to adequate notice and full and fair reviews of disability claims. However, the Department's proposed amendments to the deemed exhaustion provision will not enhance claimants' ability to obtain to a full and fair review.

Our members are very concerned that the proposed "strict adherence" is a vague standard that will create administrative and cost burdens disproportionate to any benefit to claimants. As noted above, our members devote substantial resources to complying with the current Section 503 Regulation, which provides detailed, robust claims and appeals procedures. The additional procedures the Department proposes will only add administrative and cost burdens without providing for more full or fair review.

Although we support a minor errors exception, in most cases, claimants will not know about the exception or will not have a complete understanding of how the exception applies to their claims. Therefore, it is likely that claimants will routinely request review by the courts—even when no error occurs—because it will be difficult for claimants to determine, during the pendency of a claim, if an error occurred or whether an error was minor. The DOL's proposed strict adherence standard therefore will significantly increase litigation, which will lead to increased costs for plans and, ultimately, participants.

Likewise, the proposed de novo review and additional procedures when a court rejects a claimant's request for immediate review only add administrative and cost burdens without any clear benefit to participants. Like the strict adherence standard, these rules will substantially increase litigation and administrative complexity but will not provide additional clarity at the outset as to how participants should proceed with their claims.

Therefore, we recommend that final regulations eliminate the proposed amendments to the current deemed exhaustion provision. If final regulations do include the Departments' proposals, we recommend that the regulations require claimants to first raise any

potential errors with plans and allow plans an opportunity to cure before proceeding to court under section 502(a) of ERISA.

IV. Culturally and Linguistically Appropriate Notices

Final regulations should not include the proposed requirements related to culturally and linguistically appropriate notices.

Finally, our members are concerned that the proposed requirements related to culturally and linguistically appropriate notices will present substantial administrative and cost burdens for plans. Many of our members have already committed substantial resources to providing language assistance for their non-English speaking participants. However, the Department's proposal would require plans to automatically make specific services available, regardless of plans' specific populations and needs. We recommend that plans continue to have flexibility to design their non-English language resources to fit their employee populations.

Again, thank you for considering our comments. Please contact me or Steven Wojcik, the National Business Group on Health's Vice President of Public Policy, at (202) 558-3012 if you would like to discuss our comments in more detail.

Sincerely,

Brian Marcotte
President