January 19, 2016

The Honorable Phyllis C. Borzi
Assistant Secretary, Employee Benefits Security Administration
United States Department of Labor
200 Constitution Ave NW
Washington DC 20210

Submitted at www.regulations.gov

Re: Comments on Notice of Proposed Rulemaking on Claims Procedure for Plans Providing Disability Benefits 80 Fed. Reg. 72014 (Nov. 18, 2015)

Dear Assistant Secretary Borzi:

These comments are submitted on behalf of the undersigned members of the Consortium for Citizens with Disabilities (CCD). The CCD is a working coalition of national consumer, advocacy, provider, and professional organizations working together with and on behalf of the approximately 57 million children and adults with disabilities and their families living in the United States.

We appreciate the opportunity to comment on the notice of proposed rulemaking (NPRM) that the Department of Labor issued on November 18, 2015 regarding the claims procedures for disability plans under the Employee Retirement Income Security Act (ERISA) of 1974.

The undersigned organizations strongly support the proposed updates to the regulations implementing section 503 of ERISA contained in this NPRM that clarify the responsibilities of insurers to provide adequate notice of claim denials and full and fair reviews of denial appeals as is required under section 503 of ERISA. The claims and appeals process in disability insurance claims is opaque and claimants often don't understand why the initial decision to deny their claim was made, what evidence they need to submit on appeal, when evidence has to be submitted by in order to be considered, or what evidence the insurer relied upon to deny the claim on appeal.[1] The undersigned organizations believe that the updates to the section 503 regulations are necessary to ensure transparency in the claims and appeals process and to ensure that insured individuals get a full and fair review of their claim as is envisioned (and required) by section 503 of ERISA.

Our comments regarding the specific provisions and responses to the request for comment on issues not directly addressed in the NPRM follow.

§ 2560.503-1(b)(7) Impartiality of Decision Makers

The undersigned organizations strongly support requiring insurers to ensure that their personnel policies and payments to contractors do not unfairly bias employees or independent medical examiners toward denial of claims or reward employees or contractors for doing the same. Unfortunately, disability insurers have a history of personnel practices that have rewarded employees for denying claims in a way that has biased their employees and prevented a full and fair review of claims for disability benefits, as well as a history of paying contractors to provide evidence that a claimant is not disabled.[2]

We strongly support this provision and the wording to include all persons involved in the disability decision making process whether the individual is an employee or a contactor. We would suggest however that the language be strengthened so that the provision reflects not only policies that discuss prospective decisions but past decisions as well. We therefore suggest the language be changed to read, "…Accordingly, decisions regarding hiring, compensation, termination, promotion, **bonuses** or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the **fact that an individual has** or the likelihood that the individual will support the denial of benefits." (suggested changes bolded)

§2560.503-1(g)(1)(vii) and §2560.503-1(j)(6)(i)-(ii) Notice Requirements for Adverse Benefit Determinations

The undersigned organizations strongly support the enhanced notice requirements proposed in these sections. The lack of information provided to claimants at both the initial claim and the appeals level unfairly disadvantages claimants both during the claim and appeals process, as well as in court should the claimant file a case after a final administrative denial, and impedes the ability of the insurer to complete a full and fair review.[3] Requiring insurers to provide a full discussion of its decisions at all levels of administrative review (initial claim and appeal), including why the plan did not follow recommendations of treating physicians (if applicable), any internal rules that the plan relied upon in making the decision (or that no such rules exist), and that the claimant is able to access at no cost a copy of the full file, including all evidence upon which the insurer relied to make the decision, is integral to the claimant receiving a full and fair review of their claim and appeal (see also our discussion of §2560.503-1(h)(4) below).

§2560.503-(1)(g)(1)(viii) and § 2650.504-1 (p) Culturally and Linguistically Appropriate Manner

The undersigned organizations commend the Department for including a requirement that adverse determination notices be provided in a culturally and linguistically appropriate manner to those literate in an applicable non-English language. This demonstrates an understanding of how important it is that limited English proficient (LEP) individuals receive complete information about their benefits in a manner they can understand.

However, this proposal does not go far enough. First, the "10 percent or more" standard is far too high for the definition of an "applicable non-English language." A more appropriate standard would be for 5 percent or more of the population residing in a county to be literate only in the same non-English language. For example, in 2011, the Centers for Medicare & Medicaid Services (CMS) in the Department of Health and Human Services revised the requirements for plans participating in the Medicare Advantage and the Medicare Prescription Drug Benefit (Part D) Programs to strengthen beneficiary protections, by requiring plan sponsors to translate marketing materials into any non-English language that is the primary language of at least 5 percent of the individuals who reside in a plan's service area, when the threshold had previously been set at 10 percent in 2005.[4]

Second, the Department should require plans to provide all vital documents, such as the terms and conditions of the plan, notices regarding any changes to those terms and conditions, and general descriptions of procedural rights, in an applicable non-English language upon request, not just notices of adverse action. It is crucial that plans provide persons with limited English proficiency meaningful access to their benefits by ensuring they have access to this information in a language they can understand.

Third, the Department includes a requirement for plans to provide oral language services including answering questions and providing assistance with filing claims and appeals only to those speaking "an applicable non-English language," which is again defined by the "10 percent or more" standard. We urge the Department to follow the standard set by CMS in 2011, when it clarified its requirement for Medicare Advantage and Part D plans to provide oral language services (such as through a toll-free customer call center) for all languages that are served in common by the largest commercial interpretation service providers in the U.S., which cover approximately 150 to 180 languages.[5] CMS clarified that plans "may use on-site interpreters, contract with a commercial interpretation service provider, or employ some combination of both approaches. For instance, many MA organizations and Part D sponsors provide Spanish language interpretation on-site while using one of the numerous and readily available commercial interpreter services to providers for other languages."[6] The Department should put a similar requirement in place for all plans regardless of the percentage of non-English speaking beneficiaries in a particular county.

Finally, the Department proposes to require plans to include a prominent statement in all English notices clearly indicating how to access the language services provided by the plan. But once again, this statement must only be provided in "an applicable non-English language," which is defined by the "10 percent or more" standard. Instead, we again urge the Department to follow the lead set by CMS, which requires all Medicare Advantage and Part D plans to include a "Multi-Language Insert" with their materials, which contains information translated into multiple languages, including Spanish, Chinese, Tagalog, French, Vietnamese, German, Korean, Russian, Arabic, Italian, Portuguese, French Creole, Polish, Hindi, and Japanese, regarding the availability of free interpreter services through their toll-free customer call centers.[7]

By enhancing the standards provided for in 29 CFR § 2560.503–1(p) in these ways, we expect that the Department's proposal to provide information to LEP beneficiaries "in a culturally and linguistically appropriate manner" would be more fully realized.

§ 2560.503-1(h)(4) Requirements for a Full and Fair Review

The undersigned organizations fully support these proposed changes. The current regulations permit insurers to base their denials, at both the claim and review stage, on information that the claimant may never have seen and is never able to see. This makes it exceptionally difficult for claimants to refute improper adverse determinations.

Section 4(i) of the proposed regulations would allow claimants to review their claims files and give them the opportunity to present evidence and testimony during the claims and appeals process. This will increase the quality of decision making by ensuring that claims files are as complete as possible. As a result, claimants may be less likely to request reviews of decisions or file lawsuits regarding denial of coverage.

However, when a claimant does request review of an adverse decision, section 4(ii) of the proposed regulations provides appropriate access to information. The proposed regulations in 4(ii) would require plans to provide claimants with any new or additional evidence considered, relied upon, or generated by the plan in connection with the claim. Claimants would have a reasonable opportunity to respond prior to the plan providing a notice of adverse benefit determination on review. This is a continuation of the insurer's obligation in section 4(i) to provide access to the claimant's complete case file. Allowing claimants to review the evidence used to make insurance determinations and respond to it allows for more complete case files. Given that at least some of the evidence contemplated by section 4(ii) is generated by or at the direction of the plan, and all of the evidence is in the plan's possession, the plan administrator is best positioned to supply this evidence to the claimant.

Section 4(iii) of the proposed rules would require plans that use new or additional rationales on review to provide claimants with a copy of the rationale and reasonable opportunity to respond to it. Like the other portions of Section 4, this provision remedies some of the information asymmetries that currently occur in disability benefit determinations. This provision does not restrict plans' ability to use new or additional rationales in adverse determinations; it merely reduces the chance that such determinations will be incorrect, or that additional evidence will be submitted in later stages of the appeals process. Furthermore, the requirement that new or additional rationales be supplied free of charge to the claimant is not particularly onerous. A rationale need not be lengthy. Plans are not required to supply new or additional rationales when making adverse benefit determinations on review; they can simply uphold their initial determinations using their initial rationales. Finally, this provision encourages plans to include all applicable rationales in their initial denials, thus further increasing the quality of decision making.

§2560.503-1(l) Failure to establish and follow reasonable claims procedures

The undersigned organizations support the inclusion of these proposed provisions in the final regulations. The remedies available to individuals under 502(a) of ERISA are the only way that plan participants can enforce their rights when an insurance company is acting in bad faith or otherwise not honoring the terms of the insurance contract. Deeming the failure to establish or follow reasonable claim procedures that meet the requirements in these regulations to be administrative exhaustion for the purposes of the ability to access the civil remedies provided through 502(a) is important. This provision will provide clarity to individuals as to when they

can proceed to file in court and will not miss the applicable statute of limitations due to not knowing when it is okay to file. It will also provide clarity to judges regarding when administrative exhaustion has occurred and help eliminate confusion as to when the period of the statute of limitations for filing suit begins.[8]

§2560.503-1(m)(4) Including rescission as an adverse benefit determination under certain circumstances

The proposed regulation would amend the definition of adverse benefit determination to include rescission of disability insurance coverage even if the person is not currently receiving benefits. The undersigned member organizations of CCD support this amendment as proposed because it seeks to close a loophole in the current ERISA regulations. We believe that this amendment will protect beneficiaries against the unfair retroactive cancellation or discontinuance of benefits under most circumstances, except upon failure to pay premiums and or required contributions toward the cost of coverage. By defining rescission as an adverse benefit determination, these revised regulations will give individuals access to all of the claims procedure requirements contained in this section, which is appropriate and necessary. We strongly support this proposed amendment and urge its adoption by the Department.

§2560.503-1(m)(9) Definition of "claim file"

The NPRM proposes a new definition of the term claim file. The proposed definition references §2560.503-1(m)(8), which defines relevant information as it relates to the claimant. The undersigned member organizations of CCD support the inclusion of this new definition as it gives clear guidance as to the information claimants are to receive if they request their claim file as part of the full and fair review of every disability benefit claim. This definition also provides clear guidance to both claimants and insurers as to what must be included to satisfy the requirements of §2560.503-1 (h)(4)(i) allowing a claimant to review the claims file.

Other issues upon which the Department requested comment:

Tolling:

In response to the NPRM's request for comment on tolling and the allotted time given to plan claimants responding to decisions on their claims, the undersigned CCD member organizations recognize that the inclusion of language similar to Section 2719 of the Affordable Care Act (ACA) would be repetitive given the already existing rules allowing for consumer response during the appeals process under 29CFR2560.503-1(i). Section 2719 of ACA was established to incorporate similar provisions that did not exist for group insurance providers. Section 2719 makes multiple references to regulations in Section 503-1, which we believe already includes reasonable times allotted for response to adverse decisions during the appeal process. It should be noted that the special circumstances allowing for such extensions may vary from case to case, as the needs of any individual at the onset of disability are quite unique. Some claimants may require additional time to respond due to changes in living conditions and/or the newly acquired need for reasonable accommodations. These life changes may be quite different than those experienced during claims for standard group health insurance policies. For this reason, we believe the current regulations are sufficient for the needs of consumers covered under this regulation.

Notification regarding the statute of limitations:

The undersigned organizations strongly support including notice requirements regarding the inclusion of any and all applicable statutes of limitations for filing suit to contest an adverse benefit determination in a final determination notice in the final regulations. As discussed in the preamble to the NPRM, insurers are in the best position to know whether the insurance contract contains any statute of limitations on filing a claim in court that are different than the ones contained in state law. Claimants who receive disability insurance through an employer might never have seen the plan documents that include those contractual provisions (they are often only provided a summary of benefits). Providing that information represents a very small burden on insurers. Although the information regarding the statute of limitations contained in state law is more readily available to claimants, we encourage the Department to include a requirement that every final notice of adverse benefit determination include the deadline for appealing that determination in court, whether it is governed by a contractual statute of limitations or the one set by the state of jurisdiction. This will ensure that there is clarity for all parties, including a judge, as to when the administrative process has concluded and when the statute of limitations begins to run.

Conclusion:

The undersigned organizations strongly support the updating of these regulations to make the disability insurance claim process transparent and ensure that claimants get a full and fair review of their claim as is envisioned under section 503 of ERISA.

Sincerely,

American Association of People with Disabilities
American Association on Health and Disability
American Council of the Blind
American Foundation for the Blind
Association of University Centers on Disabilities
Autism Speaks
Autistic Self Advocacy Network
Bazelon Center for Mental Health Law
Easter Seals
Goodwill Industries International
Justice in Aging
National Alliance on Mental Illness
National Association of Disability Representatives
National Council on Behavioral Health
National Disability Rights Network
National Multiple Sclerosis Society
National Organization of Social Security Claimants' Representatives
Paralyzed Veterans of America
RESNA
The Arc of the United States

United Cerebral Palsy
United Spinal Association

Endnotes

[1] See e.g. Mark Debofsky, testimony before the 2012 ERISA Advisory Council Hearing on Managing Disability Risks in an Environment of Individual Responsibility, August 28, 2012, p 1, http://www.dol.gov/ebsa/pdf/AC-DeBofsky.pdf; see also Mala M. Rafik, testimony before the 2012 ERISA Advisory Council Hearing on Managing Disability Risks in an Environment of Individual Responsibility, August 28, 2012, p. 4, http://www.dol.gov/ebsa/pdf/AC-Rafik.pdf

[2] See e.g. The Patients Perspective in Nancy G. Klimas and Roberto Patarca Routledge eds, Disability and Chronic Fatigue Syndrome: Clinical, Legal, and Patient Perspectives, May 1, 2014, p.96; Evan George, "Doctors Paid To Aid Insurers In Disability Claim Denials," Daily Journal, October 13, 2009; David Kohn, Did Insurer Cheat Disabled Clients, CBS News, 60 Minutes, November 15, 2002, available at http://www.cbsnews.com/news/did-insurer-cheat-disabled-clients-15-11-2002/

[3] See Debofsky, id 1, p 1-3; see also Rafik, id 1, p. 1-3

[4] 76 *Federal Register* 21432, at 21512 (April 15, 2011).

[5] 76 *Federal Register* 21432, at 21502; 42 CFR § 422.111(h)(1)(iii) and 42 CFR § 423.128(d)(1)(iii).

[6] 76 *Federal Register* 21503.

[7] CMS, *Medicare Marketing Guidelines*, Section 30.5.1, issued June 12, 2012, available at https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/2014MedicareMarketingGuidelines.pdf

[8] See Debofsky, id 1, p 3 for a discussion of this issue.