January 19, 2016

Employee Benefits Security Administration
ATTENTION: Claims Procedure Regulation Amendment for Plans Providing Disability Benefits
Regulatory Identifier Number 1210-AB39
Comments submitted via emailto:e-ORI@dol.gov

Thank you for allowing us to participate in your review of the claim procedures for the adjudication of benefits under Section 503 of the Employee Retirement Income Security Act of 1974 (ERISA). We understand the need to analyze regulations based on legal developments, technology advancements and other relevant factors. We appreciate the opportunity to provide feedback on these proposed amendments.

Sedgwick Claims Management Services, Inc. (Sedgwick) is the largest third party claims administrator of integrated disability and absence management services. Our diverse client base includes privately held and publicly traded companies, companies with private equity backing, public institutions and multinational insurance providers. Twenty percent of our disability and absence management clients are Fortune 500 companies. We employ 3,000 colleagues in our disability and absence management group who serve approximately 170 clients with a total of 4.2 million lives. We understand the responsibility of administering disability benefits for an organization's most important resources – their employees. Sedgwick fully supports the overall goal of ensuring that claimants who meet plan requirements are granted benefits through efficient and effective processes.

We formed an internal committee who thoroughly evaluated the proposed amendments from varying perspectives of the claims administration process. The following commentary outlines our opinions and recommendations in three areas:

- Improvements to Basic Disclosure Requirements
- Right to Review and Respond to New Information Before Final Decision
- Deemed Exhaustion of Claims and Appeals Processes

## Improvements to Basic Disclosure Requirements

The proposed amendment includes this new provision as 2560.503-1(g)(1)(vii)(A):

A discussion of the decision, including, to the extent that the plan did not follow or agree with the views presented by the claimant to the plan of health care professionals treating a claimant or the decisions presented by the claimant to the plan of other payers of benefits who granted a claimant's similar claims

(including disability benefit determinations by the Social Security Administration), the basis for disagreeing with their views or decisions.

**Sedgwick does not support this provision as written.**

This additional language would require a plan administrator to provide an analysis of information that it might not have in its possession and/or may not fully understand. The rationale behind an approval decision is unlikely to be available for a rebuttal (just the conclusion of approval). Disability is often defined differently from plan to plan, which could lead to an approval by one payer of benefits but not another. Furthermore, one plan administrator is not an expert on the terms of other plans who granted benefits. It is not reasonable to expect one plan administrator to have the expertise, information, interpretations, and other criteria to compare, contrast and analyze benefit approvals.

**Recommendation:** Revise current section 2560.503-1(g)(1)(i) by adding the italicized language below:

The specific reason or reasons for the adverse benefit determination, ***including an explanation of why the plan did not agree with the opinion of the treating health care professional.***

1. The proposed amendment adds 2560.503-1(g)(1)(vii)(B):

Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making the adverse benefit determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist.

**Sedgwick does not support this provision as written.**

Inclusion of the actual documents (at the initial claim determination and appeal levels), instead of referencing them in the notification, may make adverse benefit determination communications unnecessarily burdensome for claimants (and administrators). This additional information would likely include details of internal processes that are irrelevant to the claim decision and would potentially distract the claimant from focusing on elements of the documentation that can actually assist in perfecting the claim.

The current language in 2560.503-1(j)(5)(i) requires the plan to either provide the documents or include a statement in the adverse benefit determination notice that such documents "will be provided free of charge to the claimant upon request." In our experience, claimants request copies of their files much more frequently than they request these supplemental documents. Claimants who want to receive the supplemental documents will receive them upon request.

**Recommendation:** Revise section 2560.503-1(j)(5)(i) with the italicized language below and apply it to both the initial claim and appeal levels:

If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, ***inclusion of*** either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the

adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request.

2. The proposed amendment adds 2560.503-1(g)(1)(vii)(C):

A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. Whether a document, record, or other information is relevant to a claim for benefits shall be determined by reference to paragraph (m)(8) of this section.

**Sedgwick supports this provision as written.**

Inclusion of this language in an adverse benefit determination notice at the initial claim level may help claimants prepare their appeals.

## Right to Review and Respond to New Information Before Final Decision

The proposed amendment includes new paragraphs 2560.503-1(h)(4)(i)-(iii):

(i) Allow a claimant to review the claim file and to present evidence and testimony as part of the disability benefit claims and appeals process;

(ii) Provide that, before the plan can issue an adverse benefit determination on review on a disability benefit claim, the plan administrator shall provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the plan (or at the direction of the plan) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of an adverse benefit determination on review is required to be provided under paragraph (i) of this section to give the claimant a reasonable opportunity to respond prior to that date; and

(iii) Provide that, before the plan can issue an adverse benefit determination on review on a disability benefit claim based on a new or additional rationale, the plan administrator shall provide the claimant, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of the adverse benefit determination on review is required to be provided under paragraph (i) of this section to give the claimant a reasonable opportunity to respond prior to that date.

**Sedgwick does not support all of these provisions as written.**

The proposed language sets up a potentially endless exchange of information with no time limitations. It is unlikely that this back and forth review of commentary would result in the production of new information. In addition, the treating provider is not an expert on the plan's definition of disability; instead, the treating provider is a resource who submits clinical information the plan then uses to make a determination as to whether or not the claimant's condition meets the plan's definition of disability. There is no advantage to the claimant for the treating provider and the plan to continuously restate their differing opinions instead of the plan deciding if the claimant's condition meets the plan's definition of disability.

Timely decision-making is part of a reasonable claims process, and the proposed language will potentially require plans to repeatedly extend the period for making a decision. The requirement of providing the information to the claimant "as soon as possible" is too vague. Additionally, including the phrase "and sufficiently in advance of the date on which the notice of the adverse benefit determination on review is required to be provided" creates tension when considered along with the potential expectation that a plan will make a decision immediately after receiving a reply from the claimant, which may not be possible. Providing information to the claimant should toll the decision-making period since the plan will need additional time to adequately review additional information.

The potentially lengthy evidence ping-pong described in the proposed regulations also could delay other employment decisions.

**Recommendation:** Sedgwick strongly recommends further review of these proposed changes.

Sedgwick supports section 2560.503-1(h)(4)(i) as proposed. It requires what is already stated in the current procedures applicable at the appeal level to also apply at the initial claim level.

Sedgwick does not support sections 2560.503-1(h)(4)(ii)-(iii) and recommends deletion.

## Deemed Exhaustion of Claims and Appeals Processes

These new paragraphs have been proposed as 2560.503-1(l)(2)(i)-(ii)

(2) In the case of a claim for disability benefits, if the plan fails to strictly adhere to all the requirements of this section with respect to a claim, the claimant is deemed to have exhausted the administrative remedies available under the plan, except as provided in paragraph (l)(2)(ii) of this section. Accordingly, the claimant is entitled to pursue any available remedies under section 502(a) of ERISA on the basis that the plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim. If 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.

(ii) Notwithstanding paragraph (l)(2)(i) of this section, the administrative remedies available under a plan with respect to claims for disability benefits will not be deemed exhausted based on *de minimis* violations that do not cause, and are not likely to cause, prejudice or harm to the claimant so long as the plan demonstrates that the violation was for good cause or due to matters beyond the control of the plan and that the violation occurred in the context of an ongoing, good faith exchange of information between the plan and the claimant. This exception is not available if the violation is part of a pattern or practice of violations by the plan. The claimant may request a written explanation of the violation from the plan, and the plan must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the administrative remedies available under the plan to be deemed exhausted. If a court rejects the claimant's request for immediate review under paragraph (l)(2)(i) of this section, on the basis that the plan met the standards for the exception under this paragraph (l)(2)(ii), the claim shall be considered as re-filed on appeal upon the plan's receipt

of the decision of the court. Within a reasonable time after the receipt of the decision, the plan shall provide the claimant with notice of the resubmission.

Current section 2560.503-1(l):

Failure to establish and follow reasonable claims procedures. In the case of the failure of a plan to establish or follow claims procedures consistent with the requirements of this section, a claimant shall be deemed to have exhausted the administrative remedies available under the plan and shall be entitled to pursue any available remedies under section 502(a) of the Act on the basis that the plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

**Sedgwick does not support these provisions as written.**

The word "strictly" creates an unrealistic standard, even with the *de minimis* exception. By adding the term "strict" to this section, even minor and inconsequential errors will create an assumption that claim procedures are not reasonable. This language encourages claimants to seek remedies in court for insignificant missteps in case management that have had no impact on claim outcomes. It is likely that these modifications will result in a significant increase in "deemed exhaustion" litigation and will needlessly both burden the courts and increase the costs associated with plan administration.

The proposed language that allows a claimant to seek an explanation for a minor violation (one that does not cause the claimant harm) may provide the reason for the error; however, it does not address a claimant's main concern which is an approval of benefits. An explanation of a minor error does not have an impact on a claims decision; otherwise, the error would not be considered minor. Therefore, including this language does not add value for any stakeholder. Instead, these proposed requirements seem to be over-engineering what is an otherwise basic communication – answering questions that are asked.

If a plan does not have reasonable claims procedures or if a plan has a pattern or practice of violations, then claimants should pursue relief in court. The current language sufficiently outlines the remedy.

**Recommendation:** Keep current paragraph 2560.503-1(l) as is.

## Costs

Although it is impossible to precisely estimate the financial impact of the proposed amendments, we anticipate an increase in the following areas:

- Administrative expenses for plans
    - Independent physicians will be required to provide additional commentary on feedback from claimants and their treating providers.
    - An increase in staff will be required to print and mail documents and to manage additional steps in claim processes.
- Administrative costs for courts and defense costs for plans – We predict a significant increase in lawsuits due to claimants "deeming exhaustion" of administrative remedies based on minor errors.

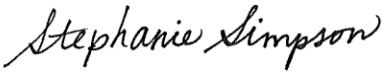
The increased costs for plans is concerning because plan sponsors may choose to compensate for the additional costs by limiting the percentage and/or duration of benefits paid by the plan. This would ultimately cause undue harm to employees.

## Timing of Effective Date

An assumption was made that the administrators of disability plans are familiar with the rules that are applicable to group health plans, but this is not necessarily accurate. Many self-insured disability plans are managed by administrators who do not adjudicate health claims. Accordingly, we request that the time for implementation be extended from 60 days after the date of publication of the final rule in the Federal Register to at least 6 months from the date of publication to allow for process updates and training.

Thank you for requesting and considering our comments. We agree that procedural protections for claimants are necessary to ensure that plan participants receive benefits due to them. We appreciate you further evaluating the proposed amendments to prevent any unintended negative consequences on claimants, employers/plan sponsors, claim administrators, and courts without improving reasonable claim process requirements. If you have questions or need additional information, please do not hesitate to contact me.

Respectfully submitted,



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