Reed Group Comments to DOL Proposed Changes to ERISA Regulations Regarding Disability Plan Administration

Reed Group, Ltd., a wholly owned subsidiary of The Guardian Life Insurance Company of America®, is the recognized leader in helping organizations reduce the cost, compliance risk and complexity of employee absence. Reed Group's products and services address FMLA, ADA, state and other leave laws, workers' compensation and short- and long-term disability programs.

Comments to 2560.503-1(h)(4)

Section (i) Please clarify that the requirement for a claimant to review the claim file and provide evidence and testimony is a requirement for both the initial claim determination and during an appeal of an adverse claim determination. Currently, the ability to review the claim file is afforded only to the appeal of an adverse claim determination.

Section (ii) Please clarify that this subsection is only regarding the appeal of an adverse claim determination and not a requirement of the initial claim determination. The current language could be read to imply that the requirement that the plan administrator provide a claimant with new or additional evidence applies to the initial claim determination. If this requirement, along with the mandate that the plan administrator give the claimant a chance to respond to the information, could greatly delay the claims administration, causing a delay in benefits to the claimant and an expensive, time-consuming process for the plan administrator.

Section (ii) The plan administrator must ensure that it's method of delivery complies with federal and state privacy laws and send the information securely, which will necessitate a cost in sending the information to the claimant.

Section (ii) Regardless whether the requirement to provide the claimant with new or additional evidence and opportunity to respond is for the initial claim determination and/or appeal process, "reasonable opportunity to respond" is not detailed enough. Also, this process creates a vicious cycle of new information and it's unclear where and when the parties stop providing new information to one another. Do the parties agree to a final and binding decision-maker, such as the second and third opinion process contained in the FMLA? If the claimant responds to the plan administrator's new information, does the plan then get to go back and obtain another independent medical exam or provider review? This is burdensome on both the plan administrator and the claimant and will require an extension of the claims administration process because under the current time frame, this amount of information exchange cannot be concluded. This will delay a claimant's claim process and determination and, therefore, potential receipt of benefits. Claimant will not be paid benefits while this process is ongoing.

As an experienced claims administrator, Reed Group is familiar with claimant's abilities to respond to deadlines and all parties, the claimant, medical provider, employer, and TPA fare better with exact deadlines and time frames, including the ability to grant an extension where warranted. Reed Group suggests that the plan administrator be required to provide the new information to the claimant within 10 days of the information provided to the administrator, that the claimant provide his or her response within 20 days of the date the administrator sent the new or additional information. If needed, the process can start again if the plan administrator needs to seek additional

information, such as another independent medical exam or peer review of the claimant's response information. If this is the case, it will take 30-45 days for the plan to initiate and schedule another peer review or independent medical exam. If there is good cause, an extension can be granted to either party. This process must include realistic time frames, but those time frames in which the parties are able to exchange and respond to new information will lengthen the claims determination and appeals process.

Section (iii): Please clarify this subsection and whether it is requiring the plan administrator to issue a sort of "pre" determination" letter. The language of this subsection suggests that the plan administrator must give the claimant an adverse determination letter that contains the plan's reasons for upholding a denial of benefits so that the claimant can respond before the official determination letter is sent to the claimant. If this is the case, this gives the claimant a mini appeal right and the plan administrator would need more details on what to do with the claimant's response to the plan administrator's "pre" determination letter. Moreover, the plan should have a right to address the claimant's response to the pre determination letter rationale, which would extend the appeal determination process by at least 60 days (30 days for claimant and another 30 days for the plan administrator to consider the claimant's response). This process seems absurd and effectively creates a second level appeal without the formal structure of such a requirement. This proposed section should be removed from the proposed regulations. *This process should not apply to a second level appeal, rather only the first level.*

Comments to 2560.503-1(J)(7) and (P)

The requirement to provide information and notices in a culturally or linguistically appropriate manner is onerous and expensive. The plan itself does not contain such requirements, so to make the notice and determination portion of the plan process have this requirement seems odd. Employers and plan administrators will have to find contractors who can provide such translations and incur costs, which would be paid for by the plan, thereby reducing the available benefits.

Requiring a plan to offer oral language translation services via a telephone hotline is reasonable. Written translation services is extremely expensive and logistically cumbersome for disability plans to implement. For example, an adverse determination letter is individualized to a claimant's specific circumstance, typically containing medical information. Requiring a plan to have the ability to translate such a letter into various languages is outside the scope of a plan administrator's usual and customary business, thereby causing the plan to incur great cost in seeking written translation services that are not readily available in the disability market. Therefore, Reed Group would propose that plan administrators be able to offer a language line to give oral translations in order to satisfy requirements under proposed section (p).

Additionally, requiring written translations of individual notifications, such as adverse determination letters takes time, sometimes up to 30 days or more, thereby further delaying the claims determination process.

In order to adhere to this proposed regulation, an administrator would need to continually stay updated on the list of changing demographics in counties to reflect whether ten percent or more of that county's population is literate in the same non-English language. Tracking such demographics is outside the role of plan administrator.

Finally, there are privacy concerns and laws that a plan would need to comply with when supplying a claimant's personal and medical information to a third party translation services; this creates added burden and expense for the plan.