



AMERICAN BENEFITS  
COUNCIL

April 8, 2011

U.S. Department of Labor  
200 Constitution Avenue, NW  
Room S-2312  
Washington, DC 20210

**Re: *Reducing Regulatory Burdens: Review Under Executive Order 13563***

Dear Sir or Madam:

I am writing on behalf of the American Benefits Council (the "Council") in response to the Department of Labor's (the "Department" or "DOL") recent request for suggestions on how it can streamline its regulations and eliminate unnecessary regulatory burdens.

The Council is a public policy organization representing principally Fortune 500 companies and other organizations that assist employers of all sizes in providing benefits to employees. Collectively, the Council's members either sponsor directly or provide services to retirement and health plans that cover more than 100 million Americans. Accordingly, the Council's comments focus on regulations that affect employee benefit plans, including both health and retirement plans.

**ELECTRONIC DELIVERY OF REQUIRED NOTICES**

The Department's rules governing the use of electronic media to provide reports, statements, notices and other documents required under Title I of the Employee Retirement Income Security Act of 1974, as amended ("ERISA") severely restrict the circumstances in which e-mail and other paperless means of communication can be utilized. The regulations contemplate the use of electronic media only if a participant either uses an electronic network, *e.g.*, a computer or a smart phone, as an integral part

of his or her duties as an employee or affirmatively consents to receiving documents electronically.<sup>1</sup>

This standard severely restricts the use of e-mail as a means of communication for many categories of employees as well as most former employees, even in circumstances where the employer has e-mail addresses and routinely uses e-mail for other forms of communication. As a result, the multitude of notices and statements that plan administrators must provide to plan participants are typically provided through labor intensive and costly paper media. There are enormous potential cost savings that would benefit employers, participants, retirees and the environment if the rules more broadly accommodated electronic communication, including the use of home computers and personal phones. We appreciate that not every participant has access to a particular system but we believe that these participants can be accommodated through rules that allow participants to opt out of electronic delivery and request paper copies of the relevant materials.

One particularly problematic aspect of the Department's current regulation is that it differs from the electronic delivery standards of other regulatory agencies, including the Internal Revenue Service ("IRS") and the Securities & Exchange Commission ("SEC"), which share oversight responsibility for employee benefit plans with the Department. The IRS standard, for example, turns on whether a participant has the effective ability to access the electronic system, not whether the participant uses a computer as an integral part of his or her job.<sup>2</sup> These different standards can be very frustrating and burdensome for employers who must comply, for example, with one set of standards in furnishing DOL-required notices, another standard in providing IRS-required disclosures, and a third standard in providing SEC-required disclosures. This patchwork is also confusing for employees and retirees.

Earlier this week, the Department published a request for information (an "RFI") that solicits comments on whether the current electronic standards are appropriate. We look forward to the opportunity to comment in more detail. We strongly believe that the Department should approach its review with an eye to reducing the regulatory burden on plan administrators and harmonizing its electronic delivery standards with those of other agencies.

## **ELIMINATION OF UNNECESSARY OR SUPERFLUOUS NOTICES AND DISCLOSURES**

We also urge the Department to conduct a careful review of the many disclosures, statements, and notices that plan administrators must provide to participants and retirees. The Department's regulations require affirmative delivery of many pieces of

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<sup>1</sup> See DOL Reg. section 2520.104b-1(c).

<sup>2</sup> Treas. Reg. §1.401(a)-21(c).

information that employees appear to routinely ignore and discard. It is very frustrating for employers to expend limited and valuable resources on notices that yield very little demonstrable benefit. These notices are wasteful and have the ultimate effect of making plans more expensive.

Among other notices, Council members have mentioned that the summary annual report (“SAR”) appears to have little communications value relative to the cost of providing the notices.<sup>3</sup> Another example is the “suspension of benefits” notice which must be provided to most defined benefit plan participants who work past normal retirement age.<sup>4</sup> The treatment of an employee who works past normal retirement age is invariably described in the plan’s summary plan description and, in our experience, the suspension of benefits notice is routinely disregarded.

### **SERIAL CHANGES IN THE REGULATORY LANDSCAPE**

In recent years, the Council has noticed the Department increasingly issues guidance in the form of interim final regulations or sub-regulatory guidance. For example, many of the regulations to date regarding the Patient Protection and Affordable Care Act (“PPACA”) have been issued in the form of interim final regulations. Additionally, other key guidance, such as the regulations implementing the Mental Health Parity and Addiction Equity Act (“MHPAEA”), have also been issued in interim final form.

Under the Administrative Procedures Act (“APA”), federal agencies are generally required, prior to the promulgation of any regulation, to publish in the Federal Register a general notice of proposed rulemaking. In addition, the APA requires that such proposed rulemaking be subject to a comment period during which interested members of the public may submit their comments regarding the rulemaking. The APA provides only limited exceptions to this rule, such as where “the agency for good cause finds . . . that notice and public procedure thereon are impracticable, unnecessary, or contrary to the public interest.” 5 U.S.C. § 553(b).

Although the APA gives the Department the authority to depart from notice-and-comment rulemaking under appropriate circumstances (such as where “good cause” exists for such a departure),<sup>5</sup> the Council urges the Department to exercise such

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<sup>3</sup> ERISA § 104(b)(3); DOL Reg. §2520.104b-10. We realize the SAR is statutorily required. However, we also believe that the Department could repurpose the requirement to allow for posting of the information. See, e.g., Field Assistance Bulletin 2006-03 (allowing posting in lieu of affirmative delivery of quarterly benefit statements).

<sup>4</sup> DOL Reg. §2530.203-3.

<sup>5</sup> We note that the use of this APA § 553(b) “good cause” authority in issuing the interim final MHPAEA regulations was challenged in *Coalition for Parity Inc. v. Sebelius*, 709 F.Supp.2d 10 (D.D.C. 2010). Although that challenge may have been unsuccessful, it does point to a growing dissatisfaction among

authority only when absolutely necessary. History has shown that the Department's adherence to the APA results in careful and deliberate rulemaking; rulemaking that is well-reasoned and that reflects broad public comment. Rules established per the APA provide consistency in rulemaking over time.

The Council understands that the Department is concerned about issuing prompt guidance in many of these areas. In many instances, Congress mandates that administrative guidance be issued within a short period of time following enactment of the underlying statute. The desire for prompt guidance, however, should not trump the necessity for clear, workable guidance. The interim final regulations governing the internal appeals and external review provisions of PPACA illustrate this point well.

The interim final regulations on claims and appeals were issued a mere four months after the enactment of PPACA. *See* 75 Fed. Reg. 43,330 (July 23, 2010). Rather than providing clear guidance to plans and issuers, however, these interim final regulations caused substantial confusion and concern. In an effort to alleviate uncertainty, the Department has now issued three separate Technical Releases (Technical Releases 2010-01, 2010-02, and 2011-01) in its attempt to explain the proper implementation of this interim final regulation and ensure that parties have sufficient time to comply. The Department has also promised an amendment to the interim final regulations. As a result of this series of guidance, a plan or issuer attempting to comply with the PPACA interim appeals and external review provisions must now trace their obligations through (1) the interim final regulations, (2) Technical Release 2010-01, (3) Technical Release 2010-02, (4) Technical Release 2011-01, and (5) once issued, the amendment to the interim final regulations. Any benefit gained by the Department's prompt issuance of the interim final regulations has, no doubt, been vitiated by the confusing and complicated nature of the subsequent guidance.

In addition to the above, certain of the recent guidance issued as interim final regulations impose substantial new requirements on plans and issuers – requirements that go well beyond that required by the governing statute. For example, certain provisions of the interim final rules governing the internal appeals and external review provisions were not required by the underlying statute and therefore should have been issued in proposed form or preceded by a Request for Information (RFI). The interim final rules impose a “strict adherence” standard on plans and issuers regarding compliance with the new internal appeals processes. Prior law provided for a “substantial compliance” standard, which provided important protections for participants, while ensuring that that claims were resolved in a timely and efficient

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affected parties regarding the Department's use of a form of rulemaking that deprives interested parties of an opportunity to comment on such rules before the rules take effect. Furthermore, even the Court in the Coalition for Parity case allowed the reliance on the APA § 553(b) “good cause” exception only because the Court “expect[ed the Department to] work diligently and expeditiously to propose final rules based on the comments that have been received in response to the Interim Final Rules,” thereby limiting the use of this exception to only truly temporary measures.

manner. Nowhere in PPACA does Congress mandate, or otherwise indicate the need for, the new “strict adherence” standard. Nonetheless, per the interim final rules, claims that are best suited for adjudication at the internal appeals phase may now be pushed into costly external review notwithstanding the best efforts of plans and issuers.

The interim final rules also go beyond the statute in defining the class of claims subject to external review by an independent review organization. External review should only apply to claims involving situations where medical judgment is involved. Questions about plan coverage terms generally should remain the purview of the plan administrator. This makes sense for many reasons, including cost considerations, efficient claims resolution, and consistency of plan interpretation. A contrary rule serves merely to increase inefficiency as well as costs for both plans and their participants.

Additionally, the interim final rules would decrease the maximum amount of time that a plan has to respond to an urgent care claim from 72 to 24 hours. This is a marked departure from the existing rules under ERISA, which provide for a 72-hour window for claim determination, and is not mandated by statute. The current ERISA regulation regarding claims procedures generally requires a plan to inform a claimant of an urgent care benefits determination “as soon as possible...but not later than 72 hours”. Therefore, plans are already required to respond as quickly as possible. In other words, the plan cannot wait 72 hours or even 24 hours before informing the claimant of the plan’s determination if the plan can inform the claimant sooner. Only where it is otherwise *impossible* for a plan to respond as soon as possible, is a plan afforded additional time, up to a total of 72 hours, to evaluate the claim. Thus, imposing a maximum 24-hour limit is, at a minimum, wholly unnecessary and, at worst, setting up plans and issuers for failure, with the likely end result being that more and more claims end up in costly external review (versus more cost-efficient internal review and appeals) or ERISA litigation. This, in turn, could lead to increased premiums for employers and employees alike.

With respect to MHPAEA, the Department issued interim rules that, in part, require the use of a unified deductible (even where, as the preamble to the interim final regulations admits, the statute does not require such a result and may indeed support an opposite result) and mandate parity of “nonquantitative treatment limitations,” a concept that does not appear in the statutory language of the MHPAEA. The use of a unified deductible limits plan-design options. Furthermore, the requirement to provide parity in so-called nonquantitative treatment limitations, both as written and in practice, goes well beyond both the language and the intent of the MHPAEA, which appears to have been concerned primarily, if not entirely, with treatment limitations of a quantitative nature. The end result of these rules is to erect imposing and potentially counter-productive new requirements without the benefit of the insight of the interested parties in the regulated industries.

The Council recognizes that some extrastatutory changes may be necessary and productive as part of comprehensive rulemaking. Without the benefit of the insight provided by public comment by a wide range of interested parties, however, the Department is merely heightening the chances that it will miss the mark with such changes. For these reasons we urge the Department to continue to look for all opportunities to issue administrative rulemaking that accords with the terms of the APA and that comes with the benefit of public dialogue.

## COORDINATION OF REGULATORY REGIMES

The Council's members often express concern about the extent to which different regulatory rules are consistent. Executive Order 13563 emphasizes the importance of agency coordination and avoiding "inconsistent" or "overlapping" rules. We applaud the Administration for this focus. In our experience, there are times in which greater coordination would be appropriate.

A recent example is the Department's proposed regulation on the definition of an investment-adviser fiduciary.<sup>6</sup> The proposed regulation would detail the circumstances in which a person providing investment-related services to a plan or IRA would be considered a plan fiduciary. At the same time, the SEC completed a study required by section 913 of the Dodd-Frank Act regarding the standards of care applicable to broker/dealers and investment advisers with respect to the provision of investment advice to retail customers, and has the authority to issue regulations subjecting broker/dealers to such rules. In addition, the Commodities Futures Trading Commission ("CFTC") has published proposed business conduct regulations regarding swaps that affect plan service providers. These three different projects have very significant interactions, rendering coordination acutely necessary. The Council believes that a single standard of care applicable under both ERISA and the securities laws would be ideal, and we urge the Department to work towards such a goal.

Another example pertains to welfare plans; specifically wellness programs. The Department, Health and Human Services ("HHS") and the IRS have all issued guidance allowing for wellness programs under the HIPAA nondiscrimination rules. Per PPACA, which codified the HIPAA wellness rules and provided for some important expansions thereof, Congress has expressly indicated its support for wellness programs. Notwithstanding, the EEOC continues to create uncertainty for plans and issuers by questioning the validity of certain incentive or award programs that otherwise comply with HIPAA and the Genetic Information Nondiscrimination Act ("GINA"). Unless and until all of the relevant agencies are able to come together and speak with one consistent voice regarding wellness programs, including those with incentive or reward components, employers and issuers are unlikely to embrace wellness programs to the

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<sup>6</sup> 75 Fed. Reg. 65,263 (Oct. 22, 2010).

extent possible; the end result being that participants lose access to important programs designed to promote better health and decrease medical costs.

A third example pertains to section 1001(5) of PPACA, which, in part, requires employer sponsors of certain group health plans to provide notice of any material modifications 60 days in advance of implementing such modifications. At the same time, existing requirements under ERISA, and related Department of Labor regulations, require sponsors of welfare plans to provide a summary of material modification within 210 days following the close of the plan year in which a material modification occurs. Providing notices to participants and beneficiaries regarding changes to their benefit plans is indeed important and ABC fully supports rules designed to ensure that all interested parties remain aware of their benefits and obligations with respect to employer-sponsored plans. We see little reason, however, why employers, and ultimately employees through their benefit plan participation, should bear the costs associated with duplicative disclosure requirements. Accordingly, we encourage the Department to consider ways in which it can eliminate these duplicative requirements, or otherwise lessen the financial burden to plans and participants in complying with such requirements.

#### **BALANCING BURDENS AGAINST POTENTIAL BENEFITS**

There are also a number of areas where we encourage the Department to carefully evaluate whether the potential benefit of a regulation is outweighed by the associated regulatory burden.

One area where the Department should be particularly careful is its current initiative to consider the extent to which fee disclosure for service providers to welfare benefit plans should be required. The Department held a hearing last fall which focused substantially on pharmacy benefit managers (“PBMs”) and raised the possibility of additional regulation in this area.<sup>7</sup>

The Council believes that enhanced disclosure in the context of health and welfare plans is appropriate only if it will provide a stronger foundation for negotiating more effectively with plan service providers. There is not a strong demand among our membership for enhanced disclosure requirements and we encourage the Department to carefully identify any perceived shortfalls before creating new disclosure requirements. Furthermore, the challenges of providing affordable health care and welfare benefits coverage in the current economic environment make Council members keenly aware of the possibility that new disclosure requirements could increase plan costs and reduce benefits without materially enhancing transparency. Before any new disclosure requirements are imposed with regard to services provided to health and

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<sup>7</sup> 75 Fed. Reg. 68,383 (Nov. 5, 2010) (notice of hearing).

welfare plans, it is critical that the Department consider that any new disclosure requirements will most likely, if not most certainly, affect either plan costs or the level of benefits provided, or perhaps both.

Another area where the cost-benefit analysis should be reconsidered has to do with the delivery of plan-related and investment-related information about participant-directed individual account plans to employees who are eligible but have not elected to participate.<sup>8</sup> While we appreciate that fee information may be germane to the decision of whether to contribute to a plan, the primary utility of the information relates to the investment of a participant's account balance among different investment options. We encourage the Department to consider whether disclosure to participants without account balances is justified given the logistical challenges for service providers who typically provide the required information.

By way of another example, the final participant fee disclosure regulations require benchmarking of investment options.<sup>9</sup> For an investment that has been in existence for less than the required periods (1, 5, and 10 years), the regulations indicate that the benchmark's rate of return must be the same duration as the investment, which means that plans may need to develop tailored benchmarks. This associated cost may not be warranted given that the Financial Industry Regulatory Authority ("FINRA") rules do not require the use of since-inception benchmarks.<sup>10</sup>

A similar issue relates to the disclosure of historic performance as part of the participant fee disclosure regulations. The regulations appear to require that performance data be set forth based on 1, 5, and 10-calendar year periods. However, some plans currently provide participants with performance data for the 1-, 5-, and 10-year periods ending on the last day of the most recently completed calendar quarter. The use of the calendar quarter rather than the calendar year as the starting point for the look-back period is derived from the SEC and FINRA advertising rules which mandate that the historic performance information "be current to the most recent calendar quarter ended prior to the submission of the advertisement for publication."<sup>11</sup> We urge the Department to

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<sup>8</sup> DOL Reg. §2550.404a-5(a); see 75 Fed. Reg. 64909 at 64912 (noting that the definition of participant includes employees who are eligible to participate under the terms of the plan without regard to whether the participant has actually become enrolled).

<sup>9</sup> DOL Reg. §2550.404a-5(d)(1)(iii).

<sup>10</sup> FINRA Rule 2210, referencing SEC Rule 482 and SEC Rule 34b-1.

<sup>11</sup> See FINRA Rule 2210(d)3 (referencing SEC Rule 482(d)3, which requires historic performance information for standardized time periods, including the preceding 1-, 5-, and 10- year periods). The preamble to the final participant fee disclosure regulations notes that EBSA expects to receive a no-action letter from FINRA indicating that compliance with the participant fee disclosure regulation is consistent with the SEC and FINRA advertising rules but this is a different issue – namely whether a plan administrator can provide more recent information in lieu of the performance information required under the regulation.



make its rule consistent with the FINRA rules. The use of calendar quarter data obviously should be permitted. Such an approach provides participants with more recent data and changes to comply with the final regulation on this point would be costly.

With respect to PPACA, section 1001(b) generally requires employers of certain group health plans to provide a summary of benefits and a coverage explanation to all participants at the time of enrollment and each subsequent year during annual enrollment. The Benefits Summary generally must be no more than four pages in length, a minimum of 12 point font, and should be written in a manner that is easy for the average participant to understand. Additionally, the Benefits Summary should contain information regarding cost sharing, continuation of coverage, limitations on coverage, and details on where participants can obtain more information.

It appears the new Benefits Summary requirement is in addition to, rather than in lieu of, the existing requirements per ERISA and related DOL regulation that plan sponsors distribute and/or make available on a periodic basis summary plan descriptions (“SPDs”) and copies of the plan itself. Additionally, a great many employers already provide benefit summaries to employees and their dependents in connection with enrollment opportunities, such as upon hire or at annual enrollment. These summaries are typically tailored to include all material information and are written in a clear and concise manner to ensure that the information being conveyed can be easily understood by the recipient employee. To layer on top of the existing regulatory requirements a new notice requirement is unnecessary and costly. Moreover, to require employers to structure their notices in a specific fashion may limit employers’ ability to convey important information in a manner that is most suitable to their employee population. For these reasons, we encourage the Department to issue a rule that takes account of existing notice and disclosure obligations, does not result in undue cost for plans and participants, and provides sufficient employer flexibility (*e.g.*, by allowing employers to continue to make use of existing benefit summaries perhaps with modification for necessary content, as set forth in regulation).

Additionally, PPACA section 1002(5) includes a requirement that plans and issuers provide plan communications pursuant to a culturally and linguistically appropriate standard. While the Council supports measures intended to ensure that all participants understand their rights and obligations, the standard set forth in the interim final regulations would impose substantial costs on employers; costs that are very likely to outweigh any corresponding benefit resulting to participants and beneficiaries.

Per the interim final rules, the standard would require employers to undergo a costly and complicated analysis to determine whether the standard applies and then requires plans to translate each notice of an adverse benefit determination or appeal into another language. Anecdotal evidence indicates that the cost of compliance for some employers and issuers could exceed \$1 million just in terms of making initial system

modifications, with ongoing administrative costs likely to include \$500 to \$1,500 per translated letter, depending on its length and content. The high costs associated with the standard set forth in the interim rules seem likely to exceed any resulting benefit to plan participants and beneficiaries. Anecdotal evidence from our members indicates that even where written translation services are made available, the majority of participants prefer oral versus written translation services. Given the high costs associated with the standard as set forth in the interim final regulations, we urge the Department to reconsider the standard and issue guidance that allow plans and issuers to provide meaningful, yet cost effective notice to participants and beneficiaries. To this end, we urge the Department to issue guidance allowing for oral versus written translation, to only require written translation upon request, and to provide a system that enables employers to decide easily and with certainty whether they are subject to the standard in the first instance.

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We appreciate the opportunity to comment on the need for regulatory simplification, and we look forward to working with you on these important changes.

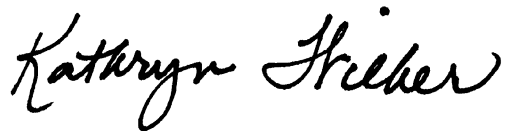
Sincerely,

Jan Jacobson



Senior Counsel, Retirement Policy

Kathryn Wilber



Senior Counsel, Health Policy