



AMERICAN BENEFITS COUNCIL

January 19, 2016

Submitted electronically via <http://www.regulations.gov>

Office of Regulations and Interpretations
Employee Benefits Security Administration
Room N-5655
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, DC 20210

Re: Proposed Claims and Appeals Regulations Regarding Disability Benefits

Dear Sir or Madam:

We write on behalf of the American Benefits Council (“Council”) to provide comments regarding the notice of proposed rulemaking published in the Federal Register on November 18, 2015, by the Department of Labor (the “Department”) entitled “Claims Procedure for Plans Providing Disability Benefits” (“Proposed Regulation”).

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 health and retirement plans that cover more than 100 million Americans.

The Proposed Regulation would amend the claims procedures regulations for plans providing disability benefits under the Employee Retirement Income Security Act of 1974 (“ERISA”). The stated intent of the Proposed Regulations is to “revise and strengthen the current rules primarily by adopting certain of the new procedural protections and safeguards made applicable to group health plans by the Affordable Care Act.” 80 Fed. Reg. 72,014 (November 18, 2015).

The Council and its members are committed to ensuring that all American workers and their families have access to valuable health and retirement benefits. As discussed below, we are concerned that certain provisions of the Proposed Regulations, while well intentioned, are contrary to congressional intent. Additionally, we are concerned that the Proposed Regulations will result in significant administrative expenses and burdens on disability plans – expenses and burdens that will increase the cost of coverage and could discourage the uptake and utilization of this important coverage by employees. We are also concerned that the economic analyses performed by the Department fails to properly take account of the increased costs and burdens that will result to employer-sponsored plans as a result of the Proposed Regulations.

We urge the Department to reconsider its Proposed Regulations and to promulgate a final rule that strikes a better balance between the goal of ensuring a full and fair review of all claims with the need for continued employee access to affordable disability coverage.

APPLYING THE EXPANDED CLAIMS RULES OF PHSA SECTION 2719 TO DISABILITY PLANS IS CONTRARY TO CONGRESSIONAL INTENT

ERISA Section 503 provides the Department with a broad grant of rulemaking authority with respect to the establishment of appropriate and reasonable claims procedures regarding ERISA-governed benefit plans. Specifically, ERISA Section 503 states:

In accordance with regulations of the Secretary, every employee benefit plan shall –

(1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and

(2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

The Department bases its Proposed Regulations on this express grant of authority.

While there can be no doubt that Congress intended to grant the Department broad authority to promulgate regulations as needed to ensure that participants receive “adequate notice” of a plan’s decision with respect to their claims, and that participants have a “reasonable opportunity” to seek a “full and fair review” of such decision by the plan’s named fiduciary, intervening Congressional acts indicate the Department’s Proposed Regulations go well beyond the scope of the Department’s intended

authority.

As noted by the Department in the preamble to the Proposed Regulations, as part of enacting the Affordable Care Act (“ACA”), Congress enacted new Public Health Service Act (“PHSA”) Section 2719. PHSA Section 2719 imposes an expanded set of claims and appeals procedures on group health plans that are subject to the ACA’s market reform provisions. PHSA Section 2719 is incorporated by reference into ERISA Section 715.

Had Congress intended for other ERISA-governed plans to be subject to such expanded claims rules, presumably Congress would have amended ERISA to impose the expanded claims and appeals rules of PHSA Section 2719 to ERISA plans, or a subset thereof (such as disability plans), more generally. Obviously, this is not what Congress did.

As discussed below, the Council is concerned about the implications of applying the claims and appeals rules of PHSA Section 2719 (or a variant thereof) to ERISA-governed disability plans. Disability plans are distinct from group health plans in many respects. Disability benefits are intended to replace lost income as a result of disability, whereas health benefits generally involve payment for a specific product or service. Health claims decisions typically look only at whether a given medical product or service is medically necessary or otherwise appropriate for the participant’s diagnosed condition. In contrast, disability claims decisions require a much more complicated and broader analysis of the claimant’s physical and mental condition.

Unlike health benefits which are often appropriate for automated processes, disability benefits are subject to highly individualized determinations and often require a fair amount of manual processing.

The government’s own programs recognize the inherent differences between health benefit and disability benefit claims. For example, the Social Security Administration (“SSA”) uses markedly different claims rules compared to the rules used by Medicare to process health claims. As but one example, the SSA indicates that it takes an average of 100+ days for the SSA to make a decision on an initial application for Social Security disability benefits.¹ This is in marked contrast to the Medicare Claims Processing Payment Manual, which states that health claims normally should be paid within 30 days.²

As the above discussion hopefully highlights, the process for administering disability claims is, by necessity, markedly different than that which can apply for medical claims. Congress recognized this when as part of the ACA it chose to only amend PHSA Section 2719 to apply expanded claims rules to certain group health plans. While Congress certainly – back in 1974 – granted the Department broad

¹ <https://www.ssa.gov/open/data/Combined-Disability-Processing-Time.html>

² <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf>

rulemaking authority with respect to the promulgation of claims rules for ERISA-governed plans, more recent Congressional actions indicate that the Department's current efforts in the form of the Proposed Regulations may go too far and in contravention of Congress' intent.

REQUIREMENT TO INCLUDE BASIS FOR DISAGREEMENT WITH THIRD PARTY DISABILITY DETERMINATION

The Proposed Regulations, in part, would amend the current disclosure requirements to require that any adverse benefit determination include a discussion of the decision, "including 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."

The Council is very concerned that this proposed new requirement improperly places the plan administrator's focus beyond the four corners of the ERISA plan. As the Department is aware, the plan administrator's obligation is to properly administer the plan in accordance with its terms. Specifically, ERISA Section 404(a)(1)(D) states that a fiduciary must "discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries ... and in accordance with the documents and instruments governing the plan."

The Proposed Regulations would now require the plan administrator to not only consider the terms of the governing plan instrument, but also to expend time, resources and attention in considering the findings of the SSA, treating physician, or "other third-party disability payor" - all of which could be based upon entirely different standards than the standard that is solely relevant to the plan's findings.

While we understand the Department's belief that "[t]his provision would address the confusion often experienced by claimants when there is little or no explanation provided for their plan's determination and/or their plan's determination is contrary to their doctor's opinion or their SSA award of disability benefits," this concern is misplaced at the expense of the ERISA plan and its participants who will now face increased coverage costs as a result. The plan administrator's role should be focused primarily on determining a claimant's eligibility for a given benefit and should not be expanded to impose a time intensive and costly requirement to explain why one or more third-party's determinations are not binding upon the plan (since they are not, by reason of ERISA Section 404(a)(1)(D), as set forth above).

Costs associated with undue administrative burden imposed upon plans as a result of the proposed regulations are not inconsequential, as even modest increases in the costs for disability coverage may discourage the uptake and/or maintenance of

disability income coverage by American workers. In a 2014 study of working consumers by the Council on Disability Awareness (“CDA”), the CDA found that while 82% of the respondents indicated that their health was one of the “most important things to protect,” only 28% said the same with respect to their income.³ One of the principal reasons that the American worker may undervalue disability coverage is because it appears the typical American worker may fail to understand the real risk of becoming disabled during the course of his or her working life. Per the CDA and the U.S. Social Security Administration, 64% of wage earners believe they have only a 2% or less chance of being disabled for 3 months or more during their working career. However, the actual odds that a worker entering the workforce today will become disabled are much greater, at about 25%.⁴

Another contributing factor appears to be price alone. The CDA Study notes that “41% of working adults would consider buying [disability income protection] if it was less expensive.”⁵

The CDA’s study’s findings are reflected in the overall enrollment rates nationally by the American worker. The most recent data from the U.S. Bureau of Labor Statistics indicates that only 33 percent of private industry workers participate in long-term disability insurance programs, with only 39 percent enrolled in short-term disability plans.⁶

The above data certainly indicates that, when compared to health coverage, the average American worker is much more price-sensitive when deciding whether to enroll in, or maintain, disability income coverage. And unlike health care, which may be subsidized, in part, from various sources, such as state and local governments, federal premium tax credits, and/or employers, the American worker may not have available the same extent of subsidies with respect to disability income coverage. As a result, any additional costs resulting from the Proposed Regulations are very likely to be borne to a greater extent by the American worker. Lastly, with respect to disability income benefits, there is no legal requirement on employers to provide, or financial penalties for failing to provide, such coverage. Employers who offer such benefits do so on a purely voluntary basis.

For all the above reasons the Council urges the Department to proceed cautiously in imposing expanded claims procedure rules on disability income coverage. It would be counterproductive if American workers are discouraged from enrolling in disability

³ “2014 Disability Awareness Study: America’s Income Protection Picture,” Council for Disability Awareness, at 5 (hereinafter “CDA Study”).

⁴ “Disability Statistics,” Council for Disability Awareness, July 2013, at 2 (citing U.S. Social Security Administration, Fact Sheet, February 7, 2013).

⁵ CDA Study at 8.

⁶ “Workers with Disability Insurance Plans,” The Economics Daily, U.S. Bureau of Labor Statistics, March, 4, 2015, accessed at: <http://www.bls.gov/opub/ted/2015/disability-insurance-plans-for-workers.htm>.

income coverage as a result of the attendant price effects resulting from the Proposed Regulations. Accordingly, we urge the Department to reconsider its current approach and adopt a final rule that more appropriately takes account of the current utilization rates and price sensitivities of the American with respect to disability income coverage.

Lastly, we note that the preamble language to the Proposed Regulation, as well as the Proposed Regulation itself indicates that a plan is only required to set forth in writing as part of the adverse benefit determination its basis for disagreeing with a third-party finding where such findings are “presented by the claimant.” Because plans may not know what other third-party findings may exist – including with respect to any “third-party disability payor,” it is imperative that plans only be required to specifically address the third-party findings where they are “presented by the claimant” to the plan as part of the appeals process. This is especially so because in many instances plan claimants may elect not to undertake the time and effort to file for SSA benefits. Even for those plan claimants who file for disability benefits with the SSA, it is quite common for the SSA to deny their initial claims request.

Accordingly, the Council requests that final regulations clearly state that a plan is only required to address third-party findings to the extent such findings are presented to the plan by the claimant. If the claimant fails to present such third-party finding, or fails to provide documentation sufficient to allow the plan to undertake a full and meaningful review of such third-party finding, the plan should be exempt from this requirement.

RIGHT TO REVIEW AND RESPOND TO NEW INFORMATION AND RATIONALE

The Proposed Regulation would also require that claimants have a right to review and respond to new evidence or rationales developed by the plan during the pendency of the appeal. Specifically, the Proposed Regulation provides that, “prior to a plan’s decision on appeal, a disability benefit claimant must 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.” See *id* at 72,017.

While the Council is supportive of all participants having a full and fair review of their claim or appeal, we are concerned that this aspect of the Proposed Regulation could result in protracted and drawn out claims processes that will result in unnecessary costs for plans (and indirectly, plan participants).

The example in the preamble language is itself perhaps the best evidence of the costly and protracted process that could occur as a result of the Proposed Regulation. Specifically, the preamble states that, “[i]f the claimant’s response happened to cause the plan to generate a third medical report containing new information, the plan would

have to automatically furnish to the claimant any new evidence in the third report.” It then goes on to state that, [t]he new evidence would have to be furnished as soon as possible and sufficiently in advance of the applicable deadline to allow the claimant a reasonable opportunity to respond to the evidence in the third report.” But what then if the claimant provides further evidence after the third report? It appears the plan would be required to issue a fourth report ... and so on ... and so on Accordingly, the Council is very concerned that the contemplated rule will result in a very protracted, costly, and cumbersome process that will adversely affect the pricing and uptake of disability income protection.

This aspect of the Proposed Regulations seems to be wholly inconsistent with the Department’s prior statements regarding the importance of providing for a “faster” and “more efficient” claims process. More specifically, in the preamble to the Department’s revisions in 2000 to the existing claims procedures, the Department makes several express references to the need for a “faster” and “more efficient” claims process for participants and beneficiaries. 65 Fed. Reg. 70,247 (November 21, 2000). For example, the Department notes that its rules are intended to “ensure that benefit claimants, at least in ERISA-covered plans, are provided *faster*, fuller, and fairer decisions on their benefit claims” (emphasis added). The Department then goes on to state, “that speedy decisionmaking is a crucial protection for claimants who need either medical care or the replacement income that disability benefits provide,” and that “[b]y limiting the reasons for which decisions may be delayed, the regulation also requires prompt decisionmaking when appropriate.” 65 Fed. Reg. at 70,247-249. Requiring a plan to engage in potentially unlimited back-and-forth with the claimant as is contemplated by the Proposed Regulation seems contrary not only to the Department’s prior statements, but to sound public policy, and should be avoided.

Additionally, many plans currently provide for a voluntary “second level” of appeal. The Council is concerned that plans may be compelled as a result of this new requirement to eliminate any current voluntary second level of appeal in order to ensure that their claims processes, in its entirety, will continue to be able to meet the requisite timing requirements or as a means to minimize costs in light of the new requirements. Under the Proposed Regulations, “[t]he plan would have to furnish the new evidence to the claimant before the expiration of the 45-day period,” and “[t]he evidence would have to be furnished as soon as possible and sufficiently in advance of the applicable deadline ... in order to give the claimant a reasonable opportunity to respond to the new evidence.”

The Department is requesting comments on “whether, and to what extent, modifications to the existing timing rules are needed to ensure that disability benefit claimants and plans will have ample time to engage in the back-and-forth dialogue that is contemplated by the new review and response rights.” *Id.* at 72,018. As the above-referenced example from the preamble demonstrates, it should be expected that the proposed rule will greatly extend the period of time during which an appeal will need

to be considered by the plan. Additionally, given the increased complexity of claims administration resulting from the proposed rule, plans will need sufficient time to ensure they are able to give proper and full review of all newly submitted information by a claimant. Unless plans are provided sufficient time and flexibility to carrying out these new obligations, we fear that many plans may feel compelled to eliminate their voluntary “second level” appeals processes. Notably, even if more time is provided to plans and claimants as part of the claims/appeals process, it seems likely that some plans, in an effort to control overall plan costs, may nonetheless feel compelled to eliminate their voluntary second levels appeals process.

If plans feel compelled to eliminate their voluntary second levels appeals processes, participants will lose access to a meaningful and affordable venue for requesting reconsideration of an adverse benefit determination. The claimant would instead have to go to federal court and incur the related legal expenses, or accept the plan’s first level appeals determination. To ensure that participants continue to have access to the plan as a cost-effective venue for resolving their claims, we urge the Department to adopt a final rule that is more mindful of potential costs and burdens imposed by the contemplated rules on plans and participants.

THE PROPOSED STRICT ADHERENCE RULE

The existing Department regulations provide, in part:

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. 29 C.F.R. 2560.503-1 (emphasis added).

This regulatory language is more commonly referred to as the “deemed exhaustion” provision.

The Proposed Regulations would amend the existing regulations to provide that “any violation of the procedural rules ... would permit a claimant to seek immediate court action,” unless the violation was (i) de minimis, (ii) non-prejudicial, (iii) attributable to good cause or matters beyond the plan’s control; (iv) in the context of an ongoing good faith exchange of information, *and* (v) not reflective of a pattern or practice of non-compliance. The claimant would be entitled to request, and receive, an explanation as to the plan’s basis for asserting that it meets this standard.

In addition to the above, the Proposed Regulation provides that if a court rejects a claimant’s request for immediate judicial review on the basis that the plan met the

standards for the “minor exception” rule described above, the claim would need to be considered by the plan as re-filed on appeal on the date the plan received the decision of the court.

Lastly, the Proposed Regulations provide that if a claimant chooses to go to court to pursue his or her claim on the basis that the procedural requirements have not been strictly followed by the plan unless there was a minor exception, “the claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary. “Consequently, rather than giving special deference to the plan, the reviewing court should review the dispute de novo.”

The Department’s intent to impose a strict adherence rule on disability plans, especially given the complex and protracted claims procedures contemplated by the Proposed Regulations, raises serious concerns for plan sponsors.

First and foremost, the Council is concerned that the proposed rule inappropriately encourages claimants to abandon the plan’s internal claims and appeals process. This is especially so given the Proposed Regulation’s contemplated rule that would effectively give claimants another chance for an internal appeal by the plan if a court decides that the plan’s errors were only “minor” and, thus, the claimant is not deemed to have exhausted his or her administrative remedies before the plan.

Requirements to exhaust administrative remedies serve the interests of all parties by promoting timely and efficient dispute resolution. The federal courts have consistently recognized the strong policy behind requiring exhaustion of administrative remedies with respect to ERISA plans. As stated by the Ninth Circuit in *Amato v. Bernard*, 618 F.2d 559, 567-68 (9th Cir. 1980):

[T]he institution of . . . administrative claim-resolution procedures was apparently intended by Congress to help reduce the number of frivolous lawsuits under ERISA; to promote the consistent treatment of claims for benefits; to provide a nonadversarial method of claims settlement; and to minimize the cost of claims settlement for all concerned . . . Moreover, the trustees of covered benefit plans are granted broad fiduciary rights and responsibilities under ERISA . . . and implementation of the exhaustion requirement will enhance their ability to expertly and efficiently manage their funds by preventing premature judicial intervention in their decision-making processes.

See also e.g., *Kross v. W. Elec. Co.*, 701 F. 2d 1238, 1244-45 (7th Cir. 1983).

The proposed rule fails to take account of well accepted legislative history, and judicial precedent, by encouraging claimants to circumvent a plan’s claims and appeals process. Under the terms of the proposed rule, there is little, if any, downside to a claimant proceeding directly to federal court and bypassing the plan’s claims process.

This is because if the court disagrees with the claimant's assertion that he or she is entitled to immediate and *de novo* judicial review as a result of the alleged procedural errors by the plan, the Proposed Regulations effectively provide the claimant with a "second bite at the appeal" [sic]. Accordingly, it should be expected that this proposed requirement would increase unnecessary litigation.

We request that final regulations ensure that claimants are not encouraged to prematurely abandon the plan's claims procedures and bring claims directly in federal court – claims that effectively waste plan assets and, in so doing, increase costs for all other participants. Possible approaches for consideration by the Department would be a rule which first requires a claimant to notify the plans of his or her intention to pursue judicial review based upon the plan's procedural error, and provide plans with a reasonable period of time to cure the noticed error prior to the claimant being allowed to go before a court. Another possible approach would be to adopt a rule providing that if a court concludes, based upon all relevant facts, that the claimant effectively abandoned the plan's claims process under the guise of claiming strict adherence, the claimant should be responsible for the plan's legal costs and/or should not be entitled to bring the claim again before the plan (if the time periods for bringing a claim before the plan have otherwise run).

We urge the Department to reconsider its proposed rule and adopt a rule that more appropriately takes account of the interests of the plan and all plan participants, as well as broader public policy interests.

THE DEPARTMENT'S ECONOMIC ANALYSIS GROSSLY UNDERESTIMATES THE COST IMPACT ON PLANS AND PARTICIPANTS

The Council believes the Department's economic analysis as set forth in Section F, "Economic Impact and Paperwork Burden" of the preamble to the Proposed Regulation fails to properly account for the financial impact of the Proposed Regulations on plans and participants.

As noted in the preamble, Executive Orders 12866 and 13563 "direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic ... effects; distributive impacts; and equity)." *Id.* at 72,020. Additionally, as noted by the Department, "Executive Order 13563 emphasizes the importance of quantifying both costs and benefits, of reducing costs, of harmonizing rules, and of promoting flexibility." *Id.*

In explaining how the Proposed Regulations meet the terms of these Executive Orders, the Department asserts that, "[t]hese requirements would impose modest costs on plan[s], because many plans already are familiar with the rules that would apply to

disability benefit claims due to their current application to group health plans.” The Council believes the assertion that disability plans are already familiar with these rules is incorrect given that many of the insurers and administrators of disability plan benefits *are not* also insurers or administrators of group health plans. . Contrary to the Department’s assertion, the Council expects that the many third-party administrators and carriers to disability benefit plans will need to start from the beginning in modifying their systems and processes to adopt changes required by final regulations.

The Department goes on to state that, “As discussed in detail in the cost Section below, the Department quantified the costs associated with two provisions of the proposed regulations: the requirement to provide additional information to claimants in the appeals process and the requirement to provide information in a culturally and linguistically appropriate manner.” *Id.* at 72,021. Apparently, these two costs are attributable to the Department’s estimate that the proposed regulations would only impose an additional \$3 million of costs *in the aggregate and across all plans*.

As discussed above, the Proposed Regulation is likely to impose a host of additional costs on plans – none of which appear to have been considered by the Department as part of its economic analysis. For example, the Department should recognize the certainty that the contemplated strict adherence rule will impose significant additional costs on plans – both as a result of having to defend more claims in court, as well as having to recommence the claims process as a result of the contemplated tolling provision.

With respect to the two provisions of the Proposed Regulations considered by the Department as part of its economic analysis, the Department’s cost estimates seem to grossly underestimate the likely costs that will result to plans. Regarding the proposed requirement that plans provide certain additional information to claimants during the claims process (see Council comments above), the Department “assume[s] that this requirement will impose an annual aggregate cost of \$1.9 million.” The Department then explains how it arrived at the \$1.9 million figure, stating:

The Department estimated this cost by assuming that compliance will require medical office staff, or other similar staff in other service setting with a labor rate of \$30, five minutes to collect and distribute the additional evidence considered, relied upon, or generated by (or at the direction of) the plan during the appeals process. The Department estimates that on average, material, printing and postage costs will total \$2.50 per mailing. The Department further assumes that 75 percent of all mailings will be distributed electronically with no associated material, printing or postage costs.

Id. at 72,023.

It is puzzling as to how the Department estimates this new requirement will only

require an additional five minutes of work on the part of the plan. As evidenced by the Department's own factual example in the preamble to the Proposed Regulations, as discussed above, the new resulting claims and appeals process would most certainly require plans to expend more than a mere additional five minutes per claim. Certainly by the time the "third medical report" is drafted and provided to the claimant, as contemplated by the Department's own example, a plan will have spent more than 5 minutes complying with the new requirement – more likely several, if not dozens, of additional hours. Accordingly, the Council is concerned that the Department's economic analysis, at least in this respect, is seriously flawed in providing an appropriate estimate of the costs that would be borne by plans as a result of the complex and protracted claims process envisioned by the Proposed Regulations.

Additionally, we are concerned that the Department's dollar estimates with respect to the cost of *delivering* this new information are similarly flawed. First, the Department estimates that 75% of time, plans will utilize electronic delivery as the means of communicating the new information to claimants. Under the Department's long-standing electronic delivery safe harbor, claims information generally cannot be provided to a claimant electronically unless they use a computer as part of their daily working activities. *See* 29 C.F.R. § 2520.104b-1(c). With respect to individuals making disability claims before the plan, it should be expected that these individuals may no longer be at work and, therefore, electronic delivery, per the Department's own rules, may not be available to the plan. Moreover, many plans choose to furnish the information in paper form specifically because the claimant may not be at work and the plans want to help ensure the claimant receives the information. Thus, it seems unlikely given current plan practice, as well as the Department's own rules regarding electronic delivery, that plans will utilize electronic delivery 75% of the time. In fact, one of our larger member companies indicated, based upon its past experience, that the company expects to only be able to use electronic delivery with respect to 30% of the claims filed under its disability plans. For these reasons, we believe the Department's estimates regarding the cost of delivery also grossly understate the likely costs to be borne by plans (and indirectly by plan participants as a whole).

The Proposed Regulations would also require plans to provide notices of adverse benefit determinations in a culturally and linguistically appropriate manner, using the standards imposed with respect to PHSA Section 2719 relating to group health plans. As the Department notes:

This requirement is satisfied if plans provide oral language services including answering questions and providing assistance with filing claims and appeals in any applicable non-English language. These proposed regulations also require each notice sent by a plan to which the requirement applies to include a one-sentence statement in the relevant non-English that translation services are available. Plans also must provide, upon request, a notice in any applicable non-English language.

The Department states that it discussed this requirement “with the regulated community,” and based upon statements from “industry experts,” estimates that the cost of complying with this requirement is \$500 per translation. The Department uses the \$500 figure to conclude that the expected costs *in the aggregate* and *across all plans* is a mere \$1.1 million.

The Council is similarly concerned that the Department’s estimate in this regard underestimates the actual costs that will be borne by plans as a result of the new requirement to provide adverse benefit determinations in a culturally and linguistically appropriate manner.

NOTICE OF APPLICABLE CONTRACTUAL LIMITATIONS PERIOD

The Department requests comments on whether the final regulation should require plans to include in the final notice of adverse benefit determination a statement of any applicable contractual limitations period and its expiration date for the claim at issue, and with an updated notice of the expiration date if tolling or some other event causes the date to change.

As noted in the preamble to the Proposed Regulation, ERISA does not specify a statute of limitations for bringing a federal action for benefits under ERISA Section 502(a)(1)(B) after the ERISA internal review process has been exhausted. Rather than being subject to varying state laws and uncertainty as to the applicable statute of limitations, many plan sponsors incorporate statute of limitations periods into their plan documents requiring plan participants to file benefit claims within a specified period of time.

In *Heimeshoff v. Hartford Life & Accident Life Ins. Co.*, 134 S. Ct. 604 (2013), the Supreme Court held that the use of such a contractual limitations period is enforceable by a benefit plan governed by ERISA provided the period is not “unreasonably short” or contrary to ERISA. The Court’s decision confirms that any ERISA plan document may include a statute of limitations period on benefit claims, even when those limitations start to run before a participant’s cause of action to file a federal claim has accrued.

The preamble to the Proposed Regulation speculates that some claimants may not have read or understood the relevant plan documents containing the statutes of limitations, and that plans may be in a better position than claimants to understand and explain any time limits.

The Council believes that a notice requirement is largely unnecessary as this information is generally already included in, and readily available to participants via

the applicable plan documents (e.g., the summary plan description (SPD)). Such a requirement could impose significant administrative burden to determine each claimant's applicable limitations period and expiration date for the particular claim at issue and then provide an update should that expiration date be tolled or otherwise change due to some intervening event.

In addition to the above, many plans utilize third-party administrators to administer their claims and appeals procedures. These service providers typically provide administrative services to tens of thousands of ERISA plans. In many instances, these service providers may not know the contractual limitations period that apply with respect to a given plan.

The Council believes that a more appropriate rule, one that better balances the interests of the plan (and its participants) with that of the claimant, would be to require that the notice of final adverse benefit determination include a statement alerting participants that they should review the terms of the applicable plan documents to determine any deadline by which they must file a civil action and the circumstances in which the deadline could be tolled or otherwise change. Such a rule would notify the claimant that there may be an applicable contractual limitations period that he or she should be aware of, and direct them to the appropriate documentation, without imposing unnecessary and material additional costs on plans (and indirectly, their participants).

CLAIMS FOR PENSION BENEFITS BASED ON THIRD PARTY DISABILITY DETERMINATIONS

As the Department notes in the preamble, the proposed changes to the claims procedures rules in the Proposed Regulations would apply to claims with respect to disability benefits under a qualified pension plan. According to the preamble, a benefit is a disability benefit subject to the proposed rules for disability claims if the plan conditions its availability to the claimant upon a showing of disability, and it does not matter how the benefit is characterized by the plan or whether the plan is a pension or welfare plan.

The Department has previously issued a series of frequently asked questions and answers relating to the processing of disability claims in which it noted that the special rules applicable to disability claims do not apply in the case of a benefit the availability of which is conditioned on a finding of disability by a third party other than the plan. Specifically, the Department's FAQ provides as follows:

However, if a plan provides a benefit the availability of which is conditioned on a finding of disability, and that finding is made by a party other than the plan for purposes other than making a benefit determination under the plan, then the special rules for disability claims need not be applied to a claim for such benefits. For example, if a pension plan provides that pension benefits shall be paid to a person who has been

determined to be disabled by the Social Security Administration or under the employer's long-term disability plan, a claim for pension benefits based on the prior determination that the claimant is disabled would be subject to the regulation's procedural rules for pension claims, not disability claims.

See FAQs About The Benefit Claims Procedure Regulation, A-9.⁷

The Council recommends that pension plans as a whole be excluded from the contemplated rules. To the extent the Department disagrees, the Council requests, consistent with the above FAQ, that final regulations at least provide that any new disability claims rules will not apply in the case of a pension plan where such plan provides pension benefits to or on behalf of a person who has been determined to be disabled by the Social Security Administration, under the employer's long-term disability plan, or by some other third party. With respect to these plans, the final regulations should specify that such a claim is treated as a claim for pension benefits that is subject to the existing claims regulation's procedural rules for pension claims.

THE EFFECTIVE DATE OF ANY FINAL RULE SHOULD PROVIDE SUFFICIENT TIME FOR IMPLEMENTATION

The Proposed Regulations would represent a very significant change in the manner in which disability claims and appeals are processed by ERISA plans. They would require, in part, the adoption by plans of revised intake and review processes, updated notices and adverse benefit determination forms, and the drafting and provision of culturally and linguistically appropriate notices. Additionally, as mentioned above, a great many employer-sponsored plans are administered by third-party administrators (if self-funded) or carriers (if insured) who have little, *if any*, experience administering the expanded claims procedures made applicable to group health plans by reason of PHSa Section 2719, as incorporated into ERISA.

To ensure that plans have the time they need to comply with new rules, the Council urges that any final rule be made effective no sooner than the first day of the plan year beginning no sooner than twelve months following publication of the final rule in the *Federal Register*. Additionally, to minimize confusion for plans and claimants, as well as to ensure that plans are not required to expend additional plan resources to reconsider claims already under review (or reviewed) by the plan, the final rule should only apply to new, initial claims filed on or after the effective date of the final rule.

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⁷ http://www.dol.gov/ebsa/faqs/faq_claims_proc_reg.html

Thank you for considering these comments submitted in response to the Proposed Regulations. If you have any questions or would like to discuss these comments further, please contact us at (202) 289-6700.

Sincerely,

A handwritten signature in black ink, appearing to read "Jan Jacobson". The signature is fluid and cursive, with a long horizontal stroke extending to the right.

Jan Jacobson
Senior Counsel, Retirement Policy

A handwritten signature in black ink, appearing to read "Kathryn Wilber". The signature is cursive and elegant, with a distinct dot above the 'i' in "Wilber".

Kathryn Wilber
Senior Counsel, Health Policy