Steven Clayburn, FSA, MAAA
Senior Director & Actuary

January 19, 2016

Submitted Electronically

Office of Regulations and Interpretations
Employee Benefits Security Administration
Room N-5666
U.S. Department of Labor
200 Constitution Avenue NW
Washington DC 20210
Attention: Claims Procedure Regulation Amendment for Plans Providing Disability Benefits

Subject: Claims Procedure for Plans Providing Disability Benefits (RIN 1210-AB39)

Dear Sir/Madam:

On behalf of the American Council of Life Insurers[1] (ACLI), we respectfully offer these comments on the Department of Labor's ("Department") proposed amendments to the ERISA claims procedures for disability income insurance. The ACLI is in complete agreement that the full and fair equitable administration of disability income claims is an important objective. But as proposed, we have concerns with many of the amendments. The Department has stated that it has incorporated the new procedural protections and safeguards made applicable to group health plans under the Affordable Care Act. 20 fed. Reg. 72014. However, the Department has failed to recognize the material differences inherent in the adjudication of disability income claims and medical claims and has overlooked the increased complexity and costs these proposals will impose on disability income claims adjudication. The proposals are also fundamentally at odds with the public policy underlying ERISA because they are likely to work as a disincentive to employers, particularly small employers, who seek to offer or continue to offer disability income coverage as a part of their employee benefit plans. Contrary to what the Department believes, the proposals are likely to increase the volume and complexity (and therefore the cost) of benefits litigation. In sum, the proposals will increase the administrative burden on insurers and other claims administrators without any tangible benefit to claimants as to the fair and equitable settlement of claims. Further, contrary to the expressed justification for the proposals, it is our view that some of the proposed changes will disrupt claims adjudication practices that have been working well for administrators and claimants for over a decade. Finally, as described below, the Department failed both to qualitatively describe the benefits of the proposed regulations, and to adequately quantify the proposed regulations' costs, a prerequisite of Federal agency rulemaking.

[1] The American Council of Life Insurers (ACLI) is a Washington, D.C.-based trade association with approximately 300 member companies operating in the United States and abroad. ACLI advocates in federal, state, and international forums for public policy that supports the industry marketplace and the 75 million American families that rely on life insurers' products for financial and retirement security. ACLI members offer life insurance, annuities, retirement plans, long-term care and disability income insurance, and reinsurance, representing more than 90 percent of industry assets and premiums.

Disability Income Insurance versus Medical Expense Insurance

The fundamental differences between health and disability claims are material to the proposed regulations. Medical claims are generally auto-adjudicated. The administrator's benefit decision is based on simple procedural questions (e.g., whether the benefit is a covered benefit, whether the procedure required a prior authorization, whether the health care provider was in or outside the network, etc.).

Disability income claims adjudication, on the other hand, requires multiple sources of information and the skilled input of many types of professionals. Since a "disability" is a contractual definition, there is a distinction between a disability and a functional impairment which may not rise to the level of a "disability" under the terms of the applicable contract. Disability claims require a much more extensive and time consuming analysis (as a claim can last years or decades), including a determination of the nature of the underlying medical condition, the extent of the individual's resulting functional deficits, and the impact on the individual's ability to work. This is why regulations that serve medical claimants will not work for disability income claimants.

Analyzing impairment against the contractual terms of disability, as noted in the preamble to the proposed amendments, is inherently factual in nature. One individual can be impaired significantly but not satisfy the contractual definition of disability, while another individual can meet the contract definition of disability with only limited impairment. For example, under an "own occupation" definition in a contract where a person is disabled if they are unable to perform their own occupation, a paraplegic who works full-time successfully as an actuary will not be contractually disabled despite a significant impairment, because of the ability to work as an actuary. At the other extreme, a concert pianist with an injury to a digital nerve will be contractually disabled despite a minor impairment because that impairment will prevent her from working as a concert pianist.

Many disability contracts contain definitions of disability that change over the pendency of a claim, typically from "own occupation" as described above to "any occupation" where a person must be disabled from performing any occupation as defined in the contract in order to continue to receive disability benefits. This adds further to the complexity of disability claim adjudication requiring the skilled judgment of a variety of professionals, including medical, vocational, and rehabilitation specialists. Many disability income policies also contain a loss-of-earnings component so that the interpretation of the definition of disability necessitates a comprehensive analysis of an insured's pre- and post-impairment earning potential.

It is precisely these distinctions that led to the claims procedure regulations being separated into two discrete components fifteen years ago.

Application of the Employee Retirement Income Security Act of 1974 (ERISA) to Disability Plans

As a threshold matter, it is important to underscore that employers are not required to offer employee benefit plans or to include disability income protection in any employee benefit plan. ERISA does not mandate that employers provide disability income insurance benefits or any other kind of welfare benefits. Congressional intent in this regard has been recognized by the courts. See e.g., Varity Corp. v. Howe, 516 U.S. 489, 497, 116 S. Ct. 1065, 134 L. Ed. 2d 130 (1996) (Congress sought "to create a system that is [not] so complex that administrative costs, or litigation expenses, unduly discourage employers from offering [ERISA] plans in the first place.") Instead, ERISA represents a "careful balancing" between ensuring fair and prompt enforcement of rights under a

plan and the encouragement of the creation of such plans. The law induces employers to offer benefits by assuring a predictable set of liabilities, under uniform standards of primary conduct and a uniform regime of ultimate remedial orders and awards when a violation has occurred. Conkright v. Frommert, 559 U.S. 506, 516-17 (2010) (citations and quotations omitted).

Within this voluntary system, an employer or other plan sponsor is free to make a number of plan design choices that will impact the overall cost of its disability income program. The current regulations, written to benefit the insured, have worked well for more than a decade. As insurers, the industry has adapted to the tighter time frames implemented in the 2000 updates and continued to comply successfully with all other requirements. For disability income claims incurred by insurers, the vast majority of these claims are paid. From the beginning of 2006 through 2014, insurers have incurred over $101 billion in short-term and long-term disability claims.[2] Of the claims that are denied, only a very small percentage are ultimately litigated. Therefore, we strongly disagree with the unfounded statement in the preamble that "*insurers and plans looking to contain disability benefit costs are often motivated to aggressively dispute disability claims*".

Specific Concerns with the Proposed Amendments

In the preamble of the proposed amendments to the established claims procedure regulations, the Department cites to a single article purporting to document the volume and constancy of litigation in disability income claims[3] and advancements in claims processing technology as rationales for the proposed rule changes. The ACLI does not agree that these rationales translate into a valid basis to amend the disability income insurance claims regulations as proposed. As we have noted above, the complexity of the disability review process does not lend itself to the "auto-adjudication" typical of the healthcare claim determination process. As such, technology advances that have expedited processing of healthcare claims do not apply to disability income claim adjudication. Further, we disagree that the proposed regulations will decrease the number of potential litigated cases. To the contrary, many of the proposed changes virtually guarantee an increase in litigated claims. The additional cost imposed thereby, as well as the costs imposed by the additional administrative burden attendant on these proposed amendments, will increase the costs for plans. Increased costs will either be passed on to participants, or employers will choose to reduce or discontinue disability income insurance altogether.[4]

A report by Charles River Associates examined the positive impact that private long-term disability plans has on public programs.[5] Reversing or halting the growth of disability benefit plans offered by private employees will have far reaching adverse effects on the nation's workforce.

---

[2] National Association of Insurance Commissioners Annual Statement Data, 2006 – 2014

[3] See footnote 8 to the preamble citing Sean M. Anderson, *ERISA Benefits Litigation: An Empirical Picture*, 28 ABA J. Lab. & Emp. L. 1 (2012). Significantly, this article does not even attempt to explain the reasons for disability claims litigation rates from 2006-2010. The period encompasses the worst of the economic recession. Yet, although it is well established that disability claims spike during periods of plant closures, layoffs and the like, there was no attempt to investigate whether the recesision influenced the increase in litigation.

[4] "Employers or other plan sponsors are generally free under ERISA, for any reason at any time, to adopt, modify, or terminate welfare plans." Curtiss-Wright Corp. v. Shoonejongen, 514 U.S. 73, 78 (1995).

[5] "Private Disability Insurance and Return-to-Work Cost Savings to SSDI and Other Federal Programs," Charles River Associates, Sept. 2013 (funded by America's Health Insurance Plans), http://www.ahip.org/PrivateDIReturntoWork82013/

Right to Review and Respond to New Information before Final Decision

At the outset, we note that Amendment No. 3 is specifically intended to apply to the pendency of an appeal. 80 Fed. Reg. 72017. However, section (h)(4)(i) of the proposal refers to "*… disability benefit **claims** and appeals **process**.*" This appears to be in error, and we recommend that this language therefore be amended to "*… disability benefit appeals process.*" To the extent that it is the intention that these amendments apply to the claims process, this change is not needed. A claimant already has the right to obtain a complete copy of the claims file and to respond to the evidence and grounds upon which the initial adverse determination was based by submitting his response and evidence on appeal. For the reasons set forth below, we do not believe that the claimant needs to have access to the entirety of the evolving claim file during the appeal process and before that process has been completed. We therefore recommend that (h)(4)(i) be deleted.

Regarding the appeal process, an insured has ample opportunity to support his/her claim and receive a full and fair, independent review on appeal. (Employers also may choose to design their disability benefit plans to include additional voluntary levels of appeal.) A claimant who receives an initial adverse benefit determination has a right to a free copy of the administrative record that contains all relevant information as defined by the regulations. The insured has six full months to review the record and develop a response. The appeal review is performed by an examiner who had no involvement in the initial claim process or decision, and the appeal gives no deference to the initial claim decision. If the initial adverse decision is upheld on appeal, the insured is provided with a detailed explanation of the administrator's reasons for the decision as required by the regulations as well as a description of his/her additional rights.

Taking all of that into account, numerous courts have recognized that a claimant does receive a full and fair review under the existing regulations. See e.g., Midgett v. Washington Group, 561 F. 3d 887 (8th Cir. 2009); Metzger v. Unum, 476 F. 3d 1161 (10th Cir. 2007); Glazer v. Reliance Standard, 2008 WL 1775437 (11th Cir. 2008); Pettaway v. Teacher's Insurance and Annuity Ass'n of America, 644 F. 3d 427 (D.C. Cir. 2011).

The proposed new subsections (h)(4)(i) and (ii) and (iii) of the regulations are also problematic, including because of their ambiguity and the impracticality of their application to the prompt administration of disability claims. It is unclear what is meant by "*new and additional evidence,*" and the amendments are certain to cause an endless back and forth of information between the plan and the claimant, needlessly delaying the appeal process and ultimately, the appeal decision.

By way of example, plans would have to send claimants new or additional evidence before the plan may have determined whether and how that evidence may contribute to an adverse appeal decision; claimants would receive new or additional evidence in piecemeal fashion as the appeal process proceeds; claimants could be required to provide comments on the new or additional information without necessarily knowing how that information may, if at all, affect the claim decision; if claimants did not want to provide a response, then the claimant could still be required to contact the plan to let them know that; and the plan may have to generate new or additional information as a result of the plan's review of the claimant's responses. This is neither practical nor desirable from the point of view of either the claimant or the plan. And once again, the endless appeal cycle will increase the costs of disability insurance without any reasonable connection to decreasing litigation.

Nevertheless, it appears that the Department wishes to provide the claimant with an opportunity to have a dialogue with the plan concerning new or additional medical evidence or information generated on appeal. 80 Fed. Reg. Footnote 13 72017. Therefore, we recommend that the Department revise "*new and additional information*" to read "*new and additional medical reviews, including Independent Medical Examination (IME) reports.*"

To avoid unnecessary delays, ensure the appeal process continues to move forward, and that appeal determinations are issued as soon as practicable, we also recommend that the Department include timeframes by which the claimant must provide his/her responses to the medical reviews, and by which the plan must review and consider the claimant's responses and issue the determination on appeal.

We recommend the following language for section (h)(4)(ii):

(ii) "Provide that, before the plan can issue an adverse benefit determination on review of a disability benefit claim, the plan administrator shall provide the claimant, free of charge, with any new or additional medical reviews considered, relied upon, or generated by the plan (or at the direction of the plan) in connection with the claim; the claimant may have up to but no more than 15 business days from receipt to respond to the medical review provided by the plan ("response period"), and the time remaining for an appeal determination shall be tolled during this response period. After receipt by the plan of the claimant's response, the plan shall have no fewer than 15 business days to issue a determination on review, but the plan must issue the decision as soon as reasonably practicable. This provision shall not apply to plans that provide a second or additional level of voluntary review."[6]

With regard to subsection 4(iii), it is not clear what is meant by "new or additional rationale." This is subject to different interpretations, in that it could mean a completely new and different ground upon which an adverse determination is based on appeal that was not a part of the initial claim determination, or alternatively, it could mean a new and different fact that, on appeal, provides further support for upholding the adverse determination.

We recommend that the Department define "new or additional rationale" to mean a completely new and different ground upon which an adverse determination is based.

We recommend the following language for section (h)(4)(iii):

(iii) "Provide that, before the plan can issue an adverse benefit determination on review of a disability benefit claim, if the plan administrator relies upon a new ground for the adverse determination which was not a basis for the initial claim determination, the plan administrator shall provide the claimant, free of charge, with the new ground. The claimant may have up to but no more than 15 business days from receipt to provide a response to the plan concerning the new ground ("response time"), and the time for an appeal determination shall be tolled during the response time. After receipt by the plan of the claimant's response, the plan shall have no less than 15 business days to issue a determination on review, but the plan must issue the decision as soon as reasonably practicable. This provision shall not apply to plans that provide a second or additional level of voluntary review.

Exhaustion of Administrative Remedies

With respect to the revisions to subsection (l) pertaining to the exhaustion of administrative remedies, the ACLI is supportive of the Department's effort to revise the regulations so that minor violations of the regulations do not result in the exhaustion of administrative remedies. Maintaining

[6] As mentioned above, the application of timeframes and tolling will ensure the appeal process moves along and does not become stalled. In addition to the example the Department has offered in the preamble, situations will arise when the claimant may not provide a response before a determination is due on day 45, or provides a response within days of the determination deadline. Imposition of time deadlines and tolling will prevent the appeal process from becoming stalled, and ensure the plan has adequate time to consider the claimant's responses and issue a determination within a reasonable time.

the integrity of the administrative review process -- as opposed to immediately litigating benefit disputes-- serves the Congressional purposes of reducing the number of frivolous lawsuits under ERISA; promoting the consistent treatment of claims for benefits; providing for a non-adversarial method of claims settlement; and minimizing the cost of claims settlement for all involved. See, e.g., Kross v. W. Elec. Co., 701 F.2d 1238, 1244-45 (7th Cir. 1983). The doctrine of exhaustion of administrative remedies also enables the Plan to obtain full information about a claim and make a reasoned decision based on the information, as well as providing "reviewing courts a factual predicate upon which to proceed." Chorosevic v. MetLife Choices, 600 F.3d 934, 941 (8th Cir. 2010), further citations omitted.

Despite these important considerations, the Department's proposed changes allow claimants to file suit, and claim exhaustion, if the plan "fails to strictly adhere to all the requirements" of Section 2560.503-1. The ability to file suit for such a violation is subject, however, to the *de minimis* violation exception found in subsection (l)(2)(ii).

The ACLI believes that the proposed test for determining whether a violation should result in administrative remedies being deemed exhausted fails to meet the goals stated above, and will guarantee increased litigation to determine whether the claim administrator's conduct fits within the *de minimis* violation exception. The proposed amendments would give rise to disputes between the claimant and the plan regarding whether the alleged procedural violation:

- was *de minimis* and that it did not, or was not likely to cause, prejudice or harm to the claimant;
- was for good cause or matters beyond the control of the plan;
- occurred in the context of an ongoing good faith exchange of information between the plan and the claimant; and,
- was "part of a pattern or practice of violations by the plan."

The proposed regulation does not require the claimant to have any communication with the plan, once the claimant has concluded that there was a procedural violation. Thus, claimants can (and likely will) proceed to file lawsuits immediately upon discerning any alleged procedural violation in the hopes that a court will apply a *de novo* standard of review. If the exception stated in subsection (l)(2) is promulgated as currently drafted, courts will then have to determine:

- whether the alleged procedural violation was *de minimis?*
- what degree of prejudice or harm is required?
- whether the harm or prejudice should only be considered in terms of the claimant's ability to obtain a full and fair review?
- whether the violations are excusable for "good cause"?
- whether an ongoing good faith exchange between the parties would still meet the requirements of the exception if it extended beyond the plan's deadlines?
- How a "pattern or practice of violations by the plan" would be determined? What number of violations would be required before a plan is determined to have been engaged in a pattern or practice of violations? Would the character of each violation be considered in determining if a pattern or practice of violations took place? If particular violations had been cured by remedial steps taken by the plan, could the plan excuse such violations from a consideration that it had engaged in a pattern or practice of violations? Would violations that occur before the applicability date of the regulation be considered?
- would discovery into other alleged violations be permitted, before the court decides if the case is ripe for adjudication?

Additionally, because some of the elements in the proposed exception go beyond the goal of permitting access to the courts when the claimant has been deprived of the ability to obtain a full and fair review, the ACLI submits that the test used in the exception is broader than it needs to be. For example, if a court concludes that a procedural violation did not occur in the context of an "ongoing good faith exchange of information," but the violation does not impact the claimant's ability to obtain a full and fair review, the remedy of exhaustion would not fit the violation.

Instead, the ACLI requests that in lieu of the multi-part test set out in subsection (l)(2)(ii) of the proposed regulation, the Department instead adopt a test similar to the one in Schorsch v. Reliance Standard Life Insurance, 693 F. 3d 734 (7th Cir. 2012) and numerous similar cases.[7] In those cases, a claimant is deemed to have exhausted administrative remedies if: "there is a lack of meaningful access to review procedures or where pursuing internal plan remedies would be futile." Schorsch, 693 F. 3d at 739.

In Schorsch, the insured claimed that the claim administrator had a different motive for denying her claim than was stated in the denial letter. Because the claimant had been told that she could obtain a review, review the pertinent documents, and submit additional information as part of an appeal, the Seventh Circuit rejected the argument that she had exhausted her administrative remedies, irrespective of the alleged violation of the claimant's right to be notified of the true reason her claim had been denied. Alternatively, if a plan refuses to provide the claimant pertinent plan documents or information from the administrative record to allow the claimant to pursue an appeal, the "meaningful access" test would allow the claimant to file suit without any further administrative review. See, e.g., Wilcynski v. Lumberman's Mut. Cas. Co., 93 F. 3d 397 (7th Cir. 1996).

Rather than developing a new set of criteria, and a new line of cases, to determine if a procedural violation excuses the exhaustion requirement, the ACLI requests that the Department replace proposed subsection (l)(2)(ii) with the following language:

> *(l)(2)(ii): Notwithstanding paragraph (l)(2)(i) of this section, the administrative remedies available under a plan with respect to disability benefits will only be deemed exhausted for violations of this section if the claimant has not been provided meaningful access to review procedures or where further review would be futile.*

The ACLI also seeks modification of the language in proposed subsection (l)(2)(ii) which allows the claimants to seek an explanation of any claimed violation from the plan, to which it must respond within ten days. The plan's response must provide a "description of the bases, if any, for asserting that the violation should not cause the administrative remedies under the plan to be deemed exhausted."

We propose that claimants should be required to make the request described in subsection (l)(2)(ii) as a prerequisite to filing suit under ERISA Section 502. We also propose that a plan receiving such a letter should have ten business days within which to provide a response. Making such a request mandatory would allow the parties to attempt to resolve disputes without resorting to litigation. Furthermore, requiring claimants to do so would promote judicial economy and clarify the administrative record for judicial review on any claimed procedural violation.

Summarizing the foregoing, the Department's proposed revisions to subsection (l) would undoubtedly lead to increased litigation. Allowing access to Federal Court on a claim of a lack of

---

[7] See, e.g., Perrino v. Southern Bell Tel. & Tel., 209 F. 3d 1309, 1316-1318 (11th Cir. 2000); Majka v. The Prudential Ins. Co. of America, 171 f. Supp. 2d 410, 414,-416 (D. N.J. 2001); Wilson v. Globe Specialty Products, 117 F. Supp 2d. 92, 98-99 (D. Mass. 2000).

"strict adherence" to all of Section 2560.503-1's numerous requirements will incentivize claimants to file suit. It can be anticipated that when such a suit is filed, claimants will immediately seek discovery to try and perfect any alleged violations. At the same time, plans and claims administrators will likely file motions to dismiss based on the *de minimis* violations exception. All of these issues will be decided in the context of a regulation that does not provide clear direction as stated above.

The net effect of this litigation for many claimants will be many months or more of delay as the courts determine whether the dispute is ripe for adjudication and resolve discovery disputes. Many courts may refuse to exercise jurisdiction over such early attempts at litigation to avoid opening the floodgates for similar litigation, and to ensure that those cases that are litigated have an adequate administrative record to review. For all of the reasons stated, the proposed changes to subsection (l) will be to bring about the exact harm that the Department seeks to avoid, namely: increased litigation and delay in claims resolution.

Improvements to Basic Disclosure Requirements

Both sections (g)(1)(vii)(A) and (j)(6)(i) of the new regulations state that an adverse benefit determination shall set forth "*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…*"

We believe it is important for a claimant to have a full understanding of how the Plan reached its decision; however, we have concerns with this new addition. First and foremost, a particular third-party decision will be irrelevant to the ERISA plan terms that are being reviewed for the benefit determination. As stated above, a determination of whether a claimant is entitled to disability benefits under a particular plan is a contractual determination. Other payers may be bound by different contractual (or sometimes statutory) definitions of disability. In order to reconcile the plan decision with the decision of other payers, the plan will need to receive and interpret the contractual or statutory language as well as determine and evaluate the medical and vocational information relied upon by the other payer. At a minimum the regulations should distinguish what is meant by another basis of determination and clarify that the claimant would need to present all of the information utilized by the third party, thus eliminating the potential of adverse selection ("cherry-picking") of information provided.

Under ERISA, a fiduciary is required to discharge its obligations in accordance with the documents and instruments governing the plan. 29 U.S.C § 1104(a)(1)(D). As a practical and legal matter, a fiduciary could never use a third party's denial as a basis to deny an ERISA-governed disability benefit, and the same can be said that a fiduciary should not rely on a third party's granting of a benefit as a basis to grant a benefit that is subject to specific ERISA plan terms. Therefore, a requirement to reconcile the different decisions is contrary to ERISA's legislative scheme.

We suggest that a better alternative is to limit the category of "other payers of benefits" regarding which the proposed rules require a discussion to SSDI decisions and treating physicians' opinions with which the claim fiduciary did not agree or did not follow. Insurers already review the administrative record from a holistic point of view and consider treating physicians' opinions and SSDI decisions. See Metropolitan Life Insurance Company v. Glenn, 554 U.S. 105 (2008). A more focused amendment would provide the benefit of adding the Department's weight to this judicial interpretation.

Application to Qualified Pension Plans

Footnote 4 in the preamble states that a benefit is a disability benefit, subject to the special rules for disability claims under the ERISA Section 503 Regulation, if the plan conditions its availability to the claimant upon a showing of disability. Footnote 4 further states that its does not matter how the benefit is characterized by the plan or whether the plan as a whole is a pension plan or welfare plan. In this regard, we note that the Department has previously addressed the application of the special rules for disability claims to a pension plan that provides that pension benefits shall be paid to 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. Specifically, in the Department's *FAQ's About the Benefit Claims Procedure Regulation*, A-9, the Department opined that under such circumstances, the claim would be subject to the regulation's procedural rules for pension claims, not disability claims.

We therefore recommend that the Department exclude pension plans from the proposed regulations. If the Department determines not to fully exclude pension plans from the proposed regulations, we recommend, consistent with the Department's position as describe above, that the disability claims regulations exclude claims with respect to a pension plan that provides that pension benefits shall be paid to 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. Such claims should be adjudicated pursuant to the existing claims regulation's procedural requirements for pension plans.

The Department's Cost Benefit Analysis is Inadequate

Congress, courts, and the executive branch of government have issued guidance mandating thorough, objective cost-benefit analysis in rulemaking. Collectively, these standards ensure that federal agencies "strike the right balance," and develop "more affordable, less intrusive rules to achieve the same ends--giving careful consideration to benefits and costs."[8] Executive branch mandates for cost-benefit analysis began in 1981 with Executive Order 12291 which created a new procedure for the Office of Management and Budget (OMB) to review proposed agency regulations, and ensured the President would have greater control over agencies and improve the quality and consistency of agency rulemaking. Since then, cost-benefit analysis has formed the core of the review process. The order unambiguously stated, "regulatory action shall not be undertaken unless the potential benefits to society for the regulation outweigh the potential costs to society."[9] Regulatory agencies, therefore, must balance the benefits of proposed regulations against their costs.

In 1993, Executive Order 12866 superseded the 1981 order, but retained cost-benefit analysis as a fundamental requirement in rulemaking. Executive Order 12866 instructs that "in deciding whether and how to regulate, agencies should assess all costs and benefits of available regulatory alternatives, including the alternative of not regulating."[10] In a manner parallel to the 1981 order, Executive Order 12866 advises that agencies must perform their analysis and choose the regulatory approach that maximizes net benefits.[11]

---

[8] Op-Ed, President Barak Obama, *Toward a 21st Century Regulatory System*, Wall Street Journal (Jan. 18, 2011). The President's Op-Ed coincided with his issuance of Executive Order 13,563, which set strict standards for cost-benefit analysis in federal agency rulemaking.

[9] 46 Fed. Reg. 13193, 13193 (Feb. 17, 1981).

[10] Exec. Order No. 12866, 3 C.F.R. 638 (1993).

[11] The 1981 and the 1993 executive orders emphasize different approaches to the same cost–benefit end. The 1981 order required that the benefits "outweigh" the costs, while the 1993 order required only that the benefits "justify" the costs. *See generally* Peter M. Shane, *Political Accountability in a System of Checks and Balances: The Case of Presidential*

President Obama reaffirmed the importance of a cost-benefit analysis in 2011 through Executive Order 13563 and reinforced the core principles in Executive Order 12866 by emphasizing that "each agency must . . . propose or adopt a regulation only upon a reasoned determination that its benefits justify its costs."[12] Importantly, five Administrations since 1981 have consistently made a cost-benefit analysis a threshold for Federal agency rulemaking.

The OMB provided Federal agencies with extensive guidance to perform cost-benefit analysis in its Circular A-4[13], which identifies three fundamental elements to Federal agency rulemaking: (i) a statement of the need for the proposed regulation; (ii) discussion of alternative regulatory approaches; and, (iii) an analysis of both qualitative and quantitative costs and benefits of the proposed action and the leading alternatives. The analysis should attempt to express both benefits and costs in a common measure—monetary units—to facilitate the assessment. When benefits or costs cannot be quantified in monetary terms or in some other quantitative measure, the Agency should describe them qualitatively.[14]

In the preamble, the Department states that, in accordance with OMB Circular A-4, it has quantified the costs where possible and provided a qualitative discussion of the benefits that are associated with the proposed regulations. As discussed below, we believe that the Department (1) failed to qualitatively describe the benefits of the proposed regulations, and (2) failed to adequately quantify the primary costs associated with the proposed regulations.

Benefits of the Proposed Regulations

In the preamble, the Department acknowledges that it "does not have sufficient data to quantify the benefits associated with these proposed regulations due to data limitations and the lack of effective measures."[15] However, much of the Department's qualitative analysis consists of the Department's "expectations" of the benefits of the proposed regulations. Indeed, the Department attempts to justify its promulgation of the proposed regulations by relying on the volume of litigation in the disability claims area[16] and the advancements in claims processing technology, stating that it "thinks that disability claimants deserve protections equally as stringent as those that Congress and the President have put into place for health care claimants under the Affordable Care Act."[17] Pursuant

---

Review of Rulemaking, 48 ARK. L. REV. 161, 176-78 (1994) (comparison of 1981 and 1993 executive orders with additional detail and observing that the 1993 "order focuses on a similar mandate, but describes it with greater nuance").

[12] Exec. Order 13563, § 1(b), 76 Fed. Reg. 3821 (Jan. 18, 2011). The order further notes that "each agency is directed to use the best available techniques to quantify anticipated present and future benefits and costs as accurately as possible." Additional analysis of this order can be found in Helen G. Boutrous, *Regulatory Review in the Obama Administration: Cost-Benefit Analysis for Everyone*, 62 ADMIN. L. REV. 243, 260 (2010).

[13] Office of Mgmt. & Budget, Circular No. A-4, Regulatory Analysis (Sept. 17, 2003), last *available at* https://www.whitehouse.gov/omb/circulars_a004_a-4/. OMB invited full public comment on his 48-page circular in draft form, which contains detailed instructions about conducing cost-benefit analysis, and provides a standard template for running the analysis.

[14] To ensure that agencies properly perform cost-benefit analysis and select the most cost-effective regulatory options, OMB and the White House Office of Information and Regulatory Affairs (OIRA) review agency cost-benefit analysis before proposed regulations become effective.

[15] 80 Fed. Reg. 72014, 72021 (Nov. 18, 2015).

[16] As indicated in footnote 3, the Department cites in the preamble a 2012 paper in support of its assertion that "disability cases dominate the ERISA litigation landscape today." However, the Department does not explain how the proposed regulations will reduce the volume of litigation.

[17] *Id.* At 72015.

to Executive Order 12866, Federal agencies should promulgate only such regulations as are required by law, are necessary to interpret the law, or are made necessary by compelling public need. The proposed regulations are neither required by law nor necessary to interpret the law. Therefore, the Department is required to establish a "compelling public need" for its regulatory action. The Department's misplaced reliance on the volume of litigation in the disability benefits area, the advancements in claims processing technology, and its "thoughts" that disability claimants deserve protections as stringent as those applicable to healthcare claimants does not demonstrate a compelling public need for regulatory action.

The Department states that it "expects" that the proposed regulations would improve the procedural protections for workers who become disabled and make claims for disability benefits. The Department, however, provides no basis for this "expectation" and, indeed, fails to provide any substantial analysis of problems with the current regulatory structure or demonstrate why the proposed additional regulatory requirements will strengthen the procedural protections currently in place.

Additionally, the Department states that the proposed regulations will cause some participants to receive benefits they might otherwise have been incorrectly denied absent the fuller protections provided by the proposed regulations. Although the proposed regulations requires additional disclosure and a right to review and respond to new information before a final appeal decision is made, the Department does not explain how these additional requirements will cause participants to receive benefits they might otherwise have been incorrectly denied. Moreover, although the Department requests comments on whether, and to what extent, modifications to the existing timing rules are needed, we are concerned the additional "back-and-forth" dialogue contemplated by some of the proposed regulations will result in an endless loop, thus not being beneficial to claimants, claim adjudicators, or employers.

As further justification for the rule, the Department states that expenditures by plans may be reduced as a fuller and fairer system of disability claims and appeals processing helps facilitate participant acceptance of cost management efforts. Yet, again, the Department provides no explanation or basis as to how the new regulations would do this. Does the Department assume that the new regulations will result in less litigation, because participants (or their attorneys) will be less likely to pursue litigation due to a "fairer system of disability claims and appeals processing"? And, if so, how?

Finally, the Department states that greater certainty and consistency in the handling of disability benefit claims and appeals and improved access to information about the manner in which claims and appeals are adjudicated may lead to efficiency gains in the system, both in terms of the allocation of spending at a macro-economic level as well as operational efficiencies. The current regulatory scheme provides both certainty and consistency with regard to the adjudication of disability benefit claims. Layering on additional requirements based on medical claim adjudication – a system far different from disability income claim adjudication – will result in disruption to the current system's certainty and consistency, leading to increased costs to and burdens on the court system to determine claim decisions.

Costs of the Proposed Regulations

The Department's analysis of the direct costs of the proposed regulations is insufficient and flawed. The Department states that it has quantified the primary costs associated with the proposed regulations requirements to (1) provide the claimant free of charge with any new or additional evidence considered, and (2) provide notices of adverse benefit determinations in a culturally and linguistically appropriate manner.

The proposed regulations would require that an adverse benefit determination contain a discussion of the decision, including the basis for disagreeing with any disability determination by the Social Security Administration, a treating physician, or other third party disability payer presented by the claimant, to the extent the plan did not follow those determinations. Compliance with this new regulatory requirement will require collection of additional information, additional claim administrator evaluation, and potentially additional medical professional analysis, thereby increasing the administrative and medical costs associated with disability claims determinations. Yet, inexplicably, the Department did not evaluate or address at all this likely substantial additional cost burden in its quantification of the primary costs associated with the proposed regulations.

Additionally, the ACLI is concerned that the Department has underestimated the costs associated with the proposal's requirement that claimants have a right to review and respond to new evidence or rationales developed by the plan during the pendency of the appeal. The Department's $1.9 million dollar annual aggregate cost estimate is based solely on the administrative functions associated with collecting and distributing the additional evidence considered, relied upon, or generated by (or at the direction of) the plan during the appeals process. The Department fails to provide any cost estimate for the time a plan would incur under the proposal to substantively evaluate claimant responses received during this proposed "back and forth" process.[18] A plan's evaluation of claimant responses to any new evidence or rationales developed by the plan during the pendency of the appeal would likely require medical professional evaluation. Yet, the Department does not include the expected cost of any such medical professional evaluation in its cost estimate.

Further, we believe the Department has underestimated the costs associated with delivering such new evidence or rationale developed by the plan during the pendency of the appeal to the claimant. The Department assumes in its cost estimate that 75 percent of all mailings will be distributed electronically with no associated material, printing or postage costs. This percentage appears exceedingly high, given that the Department's current electronic delivery safe harbor applies to participants who have the ability to effectively access documents furnished in electronic form at any location where the participant is reasonably expected to perform his or her duties as an employee and with respect to whom access to the employer's or plan sponsor's electronic information system is an integral part of those duties.[19] Thus, the Department's current policy regarding electronic delivery focuses on employees actively at work. Both long and short-term disability claimants will necessarily not be actively at work and will therefore fall outside of the Department's electronic delivery safe harbor. Finally, we do not understand why in estimating the delivery costs associated with the group health plan claims regulatory requirement to provide the claimant, free of charge, with any new or additional evidence relied upon or generated by the plan or insurer and the rationale used for a determination during the appeals process, the Department assumed that 38 percent of all such mailings will be distributed electronically, with no associated material, printing or postage costs.[20] It is illogical to assume 38 percent electronic delivery for health claims and 75 percent for disability income claims, given, as stated above, the fact that disability claimants will not be actively at work. The Department provides no rationale for its projected 37 percent increase in electronic

---

[18] Indeed, the example Department provided in the preamble of how this new provision would work contemplates the plan's generation of an additional medical report as a result of the claimant's response to new evidence generated by the plan. Yet, the Department's cost estimate does not include any costs associated with the potential of a plan being required to generate such a report.

[19] *See* 29 CFR 2520.104b-1(c)(2)(i).

[20] 75 Fed. Reg. 43330, 43344 (July 23, 2010).

delivery of disability claims information to claimants versus its prior electronic delivery estimate with regard to health claims information.

We also have several concerns with the Department's analysis of the costs associated with the proposed regulations' requirement to provide notices in a culturally and linguistically appropriate manner. In order to estimate the cost, and based on "discussions with the regulated community"[21] the Department first compares the proposed regulatory requirement with the California state law requirement providing translation services and finds that the California experience indicates that requests for written documents average 0.098 requests per 1,000 members for health claims. Although the Department acknowledges that (1) the California law is not identical to the proposed regulations, and (2) the demographics for California do not match that of the other states, the Department nonetheless uses the California translation requirement percentage to estimate the number of translation service requests that plans could expect to receive. The Department further states that industry experts told them that while the cost of translation services varies, $500 per document is a reasonable translation cost.

We note that the proposed regulations' preamble language regarding the cost of translation services is nearly identical to the preamble language utilized to estimate the cost of translation services for the Department's June 24, 2011 amendments to the Interim Final Rule implementing rules relating to internal claims and appeals for group health plans and health insurance issuers.[22] Given, as discussed above, that we are not aware of any recent discussion with the regulated community regarding the California state law translation requirement as it relates to disability income plans, it appears possible that the Department based its conclusions in this regulatory proposal on information and analysis it conducted during its promulgation of the health claims Interim Final Rule. As Executive Order 12866 requires federal agencies to "… assess both the costs and benefits of the intended regulation"[23] (emphasis added), we question the propriety of the Department's apparent utilization of discussions and analysis it conducted 4 years ago -- in the context of a different regulation -- to support the current regulatory proposal. As discussed above, there are significant differences between health claims adjudication and disability claims adjudication. It is inappropriate for the Department to utilize an analysis it undertook to promulgate a health claims regulations as support for the cost estimates in the proposed disability claims regulations.

Further, we question the Department's utilization of a $500 cost estimate for translation services. Given that the Department included the same dollar amount estimate in its interim final health claims regulations, promulgated 4 years ago, and the differences in the volume of documents associated with a health claim versus a disability income claim, we believe the Department's cost estimate is flawed.

Regulatory Alternatives

Executive Order 12866 requires Federal Agencies, in deciding whether and how to regulate, to assess the costs and benefits of available regulatory alternatives, including the alternative of not regulating.[24] The proposed regulations do not include a discussion of any regulatory alternatives

---

[21] The Department does not identify the members of the "regulated community" it had discussions with and we are not aware that the Department had discussions with any ACLI members.

[22] *See* "*Group Health Plans and Health Insurance Issuers: Rules Relating to Internal Claims and Appeals and External Review Processes*," 76 Fed. Reg. 37208, 37225 (June 24, 2011).

[23] *See* 58 Fed. Reg. 51735 (Oct. 4, 1993), Section 1(b)(6).

[24] *Id.* at Section 1(a).

contemplated or considered by the Department. Nor does the Department provide any evidence or data to conclude that the current disability claims regulatory regime is inadequate and warrants revision.

In summary, the ACLI does not believe that the Department has properly quantified or qualified the benefits associated with the proposed regulations or provided a sufficient cost analysis associated with the proposed regulatory requirements. As such, we believe that the proposed regulations as drafted could subject the proposed regulations to judicial challenge.

For the reasons stated above, the ACLI recommends that the Department withdraw the proposed regulations and re-issue them only upon a finding that there is a compelling public need for regulatory action and that the benefits of the proposed regulations justify their costs.

Areas in Need of Clarification

Culturally and Linguistically Appropriate Notices

The industry understands that translation services are needed in certain cases (the majority if not all disability carriers provide telephone assistance); however, the new requirement appears to be unduly costly as compared to the full and fair review benefits assumed to result. These requirements would also add more time to already tight time constraints that would need to change (at least as to tolling). A disability income claim file is usually voluminous, communication is frequently conducted via mail rather than electronically (unlike medical claims), and there may be some aspects of the communication (e.g., the translation of the plan provisions) that might "get lost in translation". Thus, we first recommend that any new regulations make clear that the English version takes precedence in the event of any conflict with the translated documents. Furthermore, given the fact that disability claims are unique in their potential longevity (again, years or decades) and therefore in the breadth of communication that may occur over that time, we recommend that the proposed regulations clarify that it applies only to adverse benefit determinations. Lastly, the proposal should clarify that the requirement to provide "assistance with filing claims and appeals in any applicable non-English language" is limited to procedural, not substantive, assistance.

In addition, it is not clear what value is added by the phrase "culturally appropriate" in the new regulations. Again, it seems that this is just adding wording that might have been beneficial (although we cannot determine how) for medical claims procedures; however, we cannot determine how it is defined for purposes of providing translation services in the disability claims realm. We suggest removing the word "culturally" from any final disability income insurance regulations so as to eliminate ambiguity.

Effective/Applicability Date

As currently proposed, any changes to the disability claims procedures are to take effect 60 days after publication of the final rule. This time period will not be sufficient for insurers to implement the significant practice, operational, and regulatory changes necessitated by the proposed amendments (e.g., educating and increasing staff, updating internal systems, potential 50-state policy re-filings). Therefore we urge the Department to incorporate an applicability date of at least 24 months after the effective date of the new regulations which would then apply to claims first filed on or after the applicability date. In the alternative, if the Department moves forward with the regulations without accepting this recommendation, we would urge staggered applicability dates, with the later dates for the three main areas of change: 1) right to review and respond to new information before final decision; 2) exhaustion of administrative remedies; and 3) improvements to basic disclosure requirements. This would allow appropriate measures to be incorporated by a plan. And again, in the event of staggered applicability, as was the case with the amendments which resulted in the

current regulations, we would expect the new rules to be prospective in nature and apply to claims first filed on or after a later applicability date.

Contractual Limitation Period

The Department requests public comment on the statute of limitations in ERISA cases, and specifically notice of an ERISA plan's contractual limitations period. The ACLI recommends that the final determination on appeal quote in full the applicable plan's contractual limitation provision. The ACLI believes that adopting a rule in which the determination letter must identify a specific date for the expiration of the limitation period will ultimately create confusion for claimants. In some ERISA plans, the limitations period commences on the date proof of loss is required to be provided, or on the date proof of loss is actually provided. Some jurisdictions have interpreted plan limitations to commence when a claim accrues, and accrual is a judicial term that varies by jurisdiction – as some state insurance departments have specific laws that vary by state. The proposed "right to review" provisions may result in numerous determination letters, which must be reconsidered if a claimant provides a response to new or additional information. As a result, in some ERISA plans, the deadline for filing suit will change when a new determination letter is issued, resulting in several notices to the claimant with new and revised limitation deadlines. To avoid that problem, as well as the difficulties of interpreting judicial decisions on limitations provisions that vary between jurisdictions, we recommend that the claimant be provided with the language of the limitations provision. This also will eliminate the risk that an insurer or other administrative entity is seen as providing legal advice to a claimant – something prohibited by state law.

Summary

In a voluntary system of employee benefits, each employer has a finite amount of resources to spend on compensation and benefits, including disability income plans. The disability income insurance industry believes that all claimants are entitled to a full and fair review. However, if the uniformity, predictability, and efficiency which are hallmarks of ERISA are eroded due to new regulations that seem destined to increase confusion and litigation, versus providing true benefits to American workers, an employer might reduce or shift to employees the cost of disability benefits or, in a worst case scenario, eliminate disability income benefits altogether. That was not Congress' intent in enacting ERISA. These proposed amendments will significantly add to the costs and administrative burden for a plan administrator to reasonably and timely decide benefit claims and will not decrease litigation as envisioned in the Department's preamble. We believe that the current rules may be amended to reasonably address the Department's concerns through a more focused approach that would not disrupt the careful balancing between ensuring fair and prompt enforcement of rights under a plan and the encouragement of the creation of such plans that is working for employers and workers.