

AMERICAN BENEFITS COUNCIL

YOUR ADVOCATE FOR EMPLOYER-SPONSORED BENEFITS SINCE 1967



December 11, 2017

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

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 October 12, 2017, by the Department of Labor (the “Department”) entitled “Claims Procedure for Plans Providing Disability Benefits; Extension of Applicability Date” (“Proposed Regulation”). 82 Fed. Reg. 47, 409 (October 12, 2017).

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 requests comments regarding the Department’s proposal to delay for ninety (90) days, through April 1, 2018, the applicability of the Department’s previously issued final rule amending the claims procedure requirements applicable to ERISA plans providing disability benefits (“Final Rule”). 81 Fed. Reg. 92,316 (December 19, 2016). The Proposed Regulation also solicited comments related to the cost of coverage, including on the merits of rescinding, modifying or retaining the Final Rule.

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, and as set forth in our prior comments to the Department,¹ the Council remains concerned that certain provisions of the Final Rule, if allowed to become applicable, will materially increase the costs of administering benefits for disability plans (or their service providers or carriers), with corresponding adverse effects to premium costs, coverage levels, and the uptake of disability income coverage by employees and employers.

If the Final Rule is not revised or rescinded, the Council is concerned that it will impose significant and unnecessary burdens on the regulated community that are disproportionate to any benefits that would be achieved. Accordingly, and in furtherance of the President's directive to the federal agencies in Executive Order 137777 (February 24, 2017), we urge the Department to (1) delay the application of the Final Rule as long as needed to permit the Department to engage in fulsome analysis of the potential effects of the Final Rule's provisions, and (2) take the necessary steps to strike a more appropriate 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 EXPANDED CLAIMS RULES OF PHS SECTION 2719 TO DISABILITY PLANS IS CONTRARY TO CONGRESSIONAL INTENT AND SHOULD BE AVOIDED

Per our comment letter to the Department dated January 19, 2016 (regarding the prior proposed regulation), 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.

While there can be no doubt that Congress intended to grant the Department broad

¹ American Benefits Council's January 19, 2016, comment letter to Employee Benefits Security Administration: <https://www.americanbenefitscouncil.org/pub/?id=97d4aabd-c602-4b61-fde3-50f050fba30f>.

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 Final Rule goes well beyond the scope of the Department’s intended authority.

As noted by the Department in the preamble to the Final Rule (as well as prior proposed rulemaking), Congress included new Public Health Service Act (“PHSA”) section 2719 when it enacted the Affordable Care Act (“ACA”). 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, Congress would have amended ERISA to impose the same expanded claims and appeals rules of PHSA section 2719 to ERISA plans, or a subset thereof (such as disability plans), more generally. This is not what Congress did.

The Council remains 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 a covered benefit under the terms of the group health plan and whether it is medically necessary or otherwise appropriate for the participant’s diagnosed condition. In contrast, disability claims decisions require a much more complex determination of the claimant’s physical and mental condition. Unlike health benefits which are often appropriate for automated processes, disability benefits are subject to very 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 110 days for the SSA to make a decision on an initial application for Social Security disability benefits for fiscal year 2016 (<https://www.ssa.gov/open/data/Combined-Disability-Processing-Time.html>). This is in marked contrast to the Medicare Claims Processing Payment Manual, which states that health claims normally should be paid within 30 days (<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf>).

As the above discussion 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 PHS section 2719 to apply expanded claims rules to certain group health plans. While Congress certainly – back in 1974 – granted the Department broad rulemaking authority with respect to the promulgation of claims rules for ERISA-governed plans, more recent Congressional actions indicate that the Department’s Final Rule may go too far and in contravention of Congress’ intent.

THE DEPARTMENT’S ECONOMIC ANALYSIS FAILED TO ACCOUNT FOR FULL COST IMPACT OF THE FINAL RULE ON PLANS AND PARTICIPANTS

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).” 81 Fed. Reg. at 92,332. 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.” *See id.*

Notwithstanding the express requirement to “assess all costs and benefits” and to “select regulatory approaches that maximize net benefits,” the Department acknowledges in the Final Rule that it only quantified the costs associated with two provisions of the Final Rule: (1) the requirement to provide additional information to claimants in the appeals process; and (2) the requirement to provide information in a culturally and linguistically appropriate manner. *Id.* at 92,334.²

² With respect to the two provisions of the Final Rule that were considered by the Department as part of its economic analysis, the Council believes the Department’s cost estimates seem to grossly underestimate the likely costs that will result to plans.

Regarding the requirement that plans provide certain additional information to claimants during the claims process (see Council comments above), the Department “assume[d] that this requirement will impose an annual aggregate cost of \$1.9 million.” The Department then explained how it arrived at the \$1.9 million figure, stating:

The Department estimated this cost per claim by assuming that compliance will require medical office staff, or other similar staff in other service setting with a labor rate of \$30, 30 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 30 percent of all mailings will be distributed electronically with no associated material, printing or postage costs.

81 Fed. Reg. at 92,340.

While the Department’s cost estimates regarding this provision were adjusted upwards in apparent

In numerous instances throughout the economic analysis, the Department acknowledges that it lacked data to properly quantify the costs associated with various aspects of the rulemaking. Here are but a few examples:

- “The Department also agrees that making the new or additional information or rationale available to the claimant may trigger a response from the claimant. **However, the Department does not have sufficient data** to estimate the number of claimants that will respond with information that the insurer or TPA will need to evaluate or how much time will be required to evaluate the information.” 81 Fed. Reg. 92,335 (emphasis added).
- “The requirement does impose an additional burden on plans that do not allow claimants to respond to the new information or rationale, **but the Department does not have sufficient data to estimate the increased costs.**” *See id.* (emphasis added).
- “Thus, while the Department agrees that there could be added burden imposed on plans to provide this discussion in adverse benefit determinations, the **Department is unable to estimate the burden because it does not have sufficient data** on the number or percent of claims that would need to contain this discussion.” *Id.* at 92,336 (emphasis added).

response to stakeholder comments regarding the Department’s initial cost estimate as contained in the prior proposed regulations, the Council continues to believe the cost estimate grossly underestimates the time and costs associated with this new procedural requirement.

As evidenced by the Department’s own factual example in the preamble to the prior proposed regulations, as discussed above, the claims and appeals process as set forth in the Final Rule would surely 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 five 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, was materially 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. 80 Fed. Reg. 72,017.

The Final Rule also would 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. The Department stated 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 \$533 per document. 81 Fed. Reg. 92,338. The Department used the \$533 figure to conclude that the expected costs *in the aggregate* and *across all plans* are a mere \$1.1 million. *See id.* The Council remains 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.

- “The Department acknowledges that it is likely that more claimants will request this information when they are informed of their right to receive it; **however, the Department does not have sufficient data** to estimate the number of requests that will be made.” *Id.* (emphasis added).
- “**The Department did not have sufficient data** to quantify other costs associated with the final rule.” *Id.* at 92,338 (emphasis added).

As discussed in greater detail below, the Final Rule will impose a host of additional costs on plans – many of which were not accounted for by the Department as part of its quantitative economic analysis. In issuing the Proposed Regulation the Department is seeking stakeholder comment to attempt to further understand and better quantify the actual costs that are likely to be borne by plans as a result of the Final Rule, as well as the expected effects of these additional costs on the uptake of disability plans and coverage by employers and employees.

Employer plan sponsors develop comprehensive benefit strategies to address the needs of their employee populations and to attract and retain a productive workforce. They strive to provide benefit offerings to protect employees (and their families) against unexpected risk of loss, as well as the attendant financial consequences, and to help them remain productive and at work – for example through the provision of major medical coverage, dental and vision coverage, and disability income protection, to name just a few of the benefits offered.

Employers generally have finite resources or “benefit dollars” to spend. The practical effect is that when employers are confronted with a cost increase in one aspect of their benefits offering, they are generally compelled to seek corresponding benefit savings elsewhere. This can take the form of reduced coverage levels, increased employee coinsurance or premium shares, or the cessation of employer sponsorship of a given benefit plan altogether.

In designing employee benefits plans, employers must also take into account the extent to which employees value or otherwise appreciate a given benefit or offering. Notably, 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

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

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. 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

As a whole, the above data indicates that, at least 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.

Lastly, we note that unlike health care, which may be subsidized, in part, from various sources, such as state and local governments, the U.S. Treasury via 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. Thus, any additional costs resulting from the Final Rule are very likely to be borne to a greater extent by the American worker. Perhaps most significantly, unlike health coverage which must be offered by “applicable large employers” to full-time employees subject to specific requirements, or risk penalty consistent with the Affordable Care Act, there is no legal requirement that employers provide, or financial penalties for failing to provide, disability coverage. Thus, employers who offer disability benefits do so on a purely voluntary basis and will be sensitive to increases in premium costs.

In light of the foregoing, it is very important that the Department reconsider its Final Rule and better quantify the full costs that are likely to be borne by the system as a result of the procedural changes reflected in the Final rule. Otherwise, there is significant risk that the Final Rule, if made applicable in its current form, will result in increased costs and reduced coverage (both in terms of benefit levels and covered lives).

REQUIREMENT TO INCLUDE BASIS FOR DISAGREEMENT WITH THIRD PARTY DISABILITY DETERMINATION

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>.

One provision of the Final Rule that is particularly concerning is the requirement that any adverse benefit determination include a discussion of the decision, “including the basis for disagreeing with any disability determination by the SSA ..., or any views of health care professionals treating a claimant to the extent the determination or views were presented by the claimant to the plan.” 81 Fed. Reg. 92,321.

The Council remains concerned that this new requirement improperly places the plan administrator’s focus beyond the four corners of the ERISA plan. As the Department is well 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 Final Rule would require a 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, or views of a treating physician – all of which could be based upon entirely different standards than the standard that is solely relevant to the plan’s findings.

We understand the Department’s believes this 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 treating professional’s opinion or their SSA award of disability benefits.” 81 Fed. Reg. 92,333. This concern, however, 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)

RIGHT TO REVIEW AND RESPOND TO NEW INFORMATION AND RATIONALE

The Final Rule 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 Final Rule provides that, “before the plan can issue an adverse benefit determination on review on a disability benefit claim based on a new or additional rationale, the plan administrator shall provide the claimant, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided ... to give the claimant a reasonable opportunity to respond prior to that date.” 81 Fed. Reg. 92,342.

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 Final Rule 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 to the 2015 proposed regulation 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.” 80 Fed. Reg. 72,017. 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*.” *See id.* 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 Final Rule is 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 2015 proposed regulation seems contrary not only to the Department’s prior statements, but to sound public policy, and, thus, should be avoided.

Additionally, the Council notes that 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 Final Rule, “[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.” 81 Fed. Reg. 92,325.

As the above-referenced example demonstrates, it should be expected that the Final Rule, if allowed to take effect, 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 this new requirement, 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, 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 reconsider its Final Rule in this regard.

IMPOSITION OF A STRICT ADHERENCE REQUIREMENT

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 Final Rule amends these existing regulations to provide that “if a plan fails to adhere to all the requirements in the claims procedure regulation, the claimant would be deemed to have exhausted administrative remedies,” and could proceed immediately to litigation, “with a limited exception where 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” 81 Fed. Reg. 92,327 (emphasis added). 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 Final Rule 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 needs to be considered by the plan as re-filed on appeal on the date the plan received the decision of the court.

Lastly, the Final Rule provides 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 imposition of a strict adherence rule on disability plans, especially given the complex and protracted claims procedures contemplated by the Final Rule, continues to raise serious concerns for plan sponsors. Most importantly, the application of a strict adherence rule inappropriately encourages claimants to abandon the plan’s internal claims and appeals process. This is especially so given the Final Rule 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.

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 Final 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 Final 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 Final Rule effectively provides the claimant with a "second bite at the apple" (sic). Accordingly, it should be expected that this requirement, if allowed to go into effect, would increase unnecessary litigation, resulting in material economic costs on plans, with corresponding adverse effects to employers and employees (such as increased premium costs, reduced coverage levels, and/or reduced uptake or maintenance of plans or coverage).

NOTICE OF APPLICABLE CONTRACTUAL LIMITATIONS PERIOD

The Final Rule requires that that each notice of an adverse benefit determination "must include a description of any applicable contractual limitations period and its expiration date." 81 Fed. Reg. 92,331. The stated basis for this new requirement is 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 continues to believe that a notice requirement is 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. Additionally, 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.

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

The Council supports the clarification provided by the Department in the preamble to the Final Rule⁷, which excepts pension plans from the disability claims rules where the 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. We urge that any future rulemaking retain this clarification.

EFFECTIVE DATE OF ANY NEW RULE SHOULD PROVIDE SUFFICIENT TIME FOR IMPLEMENTATION

As noted above, the Council supports the Department's reconsideration of its Final Rule and efforts to more fully evaluate the potential costs associated with implementation of the Final Rule. To the extent that the Department promulgates a revised rule, the Council requests that this new rule also be issued in proposed form and allow for public comment.

To ensure that plans have the time they need to comply with any new revised rule, the Council requests that any final rule be made effective no sooner than the first day of the plan year beginning twelve months following publication of the final rule in the *Federal Register*. And 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, any new final rule should continue to only apply to new, initial claims filed on or after the effective date of a new final rule.

* * *

Thank you for considering these comments submitted in response to the Proposed

⁷ 81 Fed. Reg. 92,316 at FN 3.

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 that reads "Kathryn Wilber". The signature is written in a cursive style with a prominent dot over the 'i' in "Wilber".

Kathryn Wilber
Senior Counsel, Health Policy