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Submitted Electronically via e-ORI@dol.gov

Office of Regulations and Interpretations
Employee Benefits Security Administration
Room N-5655
U.S. Department of Labor
200 Constitution Avenue NW.
Washington, DC 20210
Attention: Claims Procedure for Plans Providing Disability Benefits Examination

Subject: Claims Procedure for Plans Providing Disability Benefits; Extension of Applicability Date (RIN 1210-AB39)

Dear Sir/Madam:

On behalf of the American Council of Life Insurers[1] (ACLI), I appreciate the opportunity to provide data and additional comments in conjunction with the Department of Labor's ("Department") extension of the applicability date, to April 1, 2018, of the final rule amending Section 2560.503-1 of the Employee Retirement Income Security Act ("ERISA"), the claims procedure regulations applicable to ERISA-covered employee benefit plans that provide disability income benefits (the "Final Rule") published on December 19, 2016.

Pursuant to Executive Order 13777,[2] the Department has concluded that it is appropriate to seek additional public input regarding the regulatory impact analysis in the Final Rule so that the Department may consider whether it supports regulatory alternatives other than those adopted in the Final Rule. Given the paucity of the data relied upon by the Department in promulgating the Final Rule, it is both necessary and appropriate for the Department to conduct such an examination. ACLI is confident that, after a full evaluation of the Final Rule and the data submitted by the ACLI, the Department will conclude that the costs imposed by the Final Rule outweigh its benefit to plan participants.

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[1] The American Council of Life Insurers (ACLI) is a Washington, D.C.-based trade association with approximately 290 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 95 percent of industry assets, 93 percent of life insurance premiums, and 98 percent of annuity considerations in the United States.

[2] Executive Order 13777, 82 Fed. Reg. 12285 (Mar. 1, 2017) is intended to reduce the regulatory burdens agencies place on the American people, and directs federal agencies to undertake specific activities to accomplish that objective, including evaluating existing regulations to make recommendations regarding those that can be repealed, replaced, or modified to make them less burdensome.

As detailed in both of our prior comment letters (attached as Exhibit B) and below, ACLI agrees that the full and fair administration of disability income claims is an important objective. However, we continue to have significant concerns that many provisions of the Final Rule will not advance that objective. These provisions will increase the administrative burden on insurers and other claims administrators without any tangible benefit to claimants. Further, contrary to the expressed justification for the Final Rule, some of the final changes will unnecessarily complicate and add to the costs of claims adjudication practices that have served both plans and claimants well for over a decade.

I. ACLI's Disability Income Carrier Survey Illustrates Significant Errors in the Department's Assumptions and Conclusions

In promulgating the Final Rule, the Department acknowledged several areas where it had limited data or insufficient data about disability claims adjudication, including such essential areas as the numbers of claims filed, approved and denied. The consideration and evaluation of such data is critical to this rulemaking. ACLI committed to work with the Department to gather data to assist the Department in its examination of the Final Rule and consideration of regulatory alternatives to the Final Rule. Consistent with this commitment, ACLI conducted a survey of insurers who offer group disability income (DI) insurance. ACLI received survey responses from companies representing over 80% of the group DI insured lives. The survey limited itself to only those DI policies that were subject to ERISA. To estimate the number of lives and plans covered under ERISA, the survey asked participants to provide the number of DI insurance policies issued, the number of plans for which the insurer was providing administrative services - only (ASO), the number of covered lives under insurance policies, and the number of lives covered under ASO plans.

Additional survey data elements included the number of claims filed in a given year, the outcome of those claims, the number of denials appealed and the outcome of those appeals, information as to the reasons for benefit denials and terminations, the number of DI-related lawsuits and their average cost, the anticipated increase in litigation and associated litigation expenses as a result of the rule, and the estimated cost to bring administrator's systems into conformance with the rule, and the anticipated annual, on-going cost to ensure conformity. Further, the survey asked insurers to estimate the number of claims that, prior to the Final Rule, would have been denied, but would now be approved solely because of the Final Rule; and we asked participants to provide an estimate of the price elasticity of DI insurance based on the survey participant's experience and actuarial models.

ACLI's Survey Results are attached as Exhibit A. All data represent estimates for total aggregate industry values.

ACLI's Survey illustrates that many of the significant premises relied upon by the Department in its rulemaking are incorrect. For example:

- The Department maintains that the Final Rule will ensure that disability plan participants receive benefits that otherwise may have been denied by plan administrators in the absence

of the fuller protections it provides.[3] ACLI's survey found that the Final Rule will result in zero additional claims being approved.

- The Department states in the preamble to the final rule that "Insurers and plans looking to contain disability costs may be motivated to aggressively dispute disability claims."[4] ACLI's survey shows that an overwhelming majority of short-term and long-term disability claims are approved upon initial review. For example, in 2016, 85.8 percent of short-term disability claims and 67.5 percent of long-term disability claims were approved following initial review.
- The Department alleges that disability claims "dominate the ERISA litigation landscape today."[5] While it may be true, as the Department alleges, that during 2006-2010 long-term disability claims accounted for 65.5 percent of all benefits litigation, the percent of disability claims actually subject to litigation is small. ACLI's survey illustrates that in 2014, 0.05 percent of all disability claims were litigated.
- The Department, by requiring that plans explain the basis for disagreeing with or not following disability determinations by the Social Security Administration (SSA), apparently believes that a majority of claimants deemed disabled by SSA are denied private long-term disability benefits, due to plan administrator "conflicts of interest."[6] ACLI's data shows that the vast majority of claimants who have been deemed disabled by the SSA are approved for long-term disability benefits by plans. Further, of those claimants who have been denied such benefits, ACLI's survey shows that the overwhelming majority were denied benefits due to reasons other than a finding that the claimant was not disabled (such as not being eligible under the terms of the policy, pre-existing conditions, or failure to provide necessary information).
- The Department disagreed with stakeholder comments regarding the increased litigation associated with the Final Rule.[7] ACLI's survey illustrates that 100 percent of carriers anticipate an increase in litigation as a result of the Final Rule, and that litigation is expected to increase 39 percent.
- Although the Department acknowledged that it lacked sufficient data to quantify many of the costs associated with the Final Rule,[8] it disagreed with stakeholder comments regarding increases in costs.[9] ACLI's survey shows that the Final Rule will result in initial costs of $19.2 million and additional annual costs of $64.5 million.
- The Department disagreed that the Final Rule would discourage employers from sponsoring plans providing disability benefits.[10] ACLI's survey illustrates that for each 1 percent increase in the price of disability coverage, the number of covered lives is expected to decrease by 1.9 percent.

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[3] 81 Fed. Reg. 92316 (Dec. 19,2016).
[4] *Id.*
[5] *Id.*
[6] Id at 92322.
[7] *Id*. at 92318.
[8] *Id.* at 92338.
[9] I*d.* at 92318.
[10] *Id*.

- The Department states that, based on discussions it has had with the regulated community, it understands that few plans base adverse benefit determinations on appeal on new evidence or rationales.[11] ACLI's survey illustrates that in 2016, 83.9 percent of short-term disability claim appeals involved new information and 82.8 percent of long-term disability claim appeals involved new information.

Summary of Survey Results – Short-term Disability Claims

	2014	2015	2016
Claims Submitted	1,917,745	2,009,803	2,077,288
Percent Approved During Initial Review	87.1	86.2	85.8
Average Number of Days to Process Claim	13	13.3	13.5
Number of STDI Claims Appealed	11,925	13,574	16,148
Percent of STDI Claims Appealed	0.6	0.7	0.8
Percent Appeals Involving New Information[12]	87.3	87.9	83.9
Percent of Appeals Denied	62.1	63.3	62.6
Percent of Appeals Approved	37.9	36.7	37.0

Summary of Survey Results – Long-term Disability Claims

	2014	2015	2016
Claims Submitted	280,179	277,826	279,950
Percent Approved During Initial Review	68.3	68.1	67.5
Average Number of Days to Process Claim	39	39	39
Number of LTDI Claims Appealed	15,440	14,779	14,335
Percent of LTDI Claims Appealed	5.5	5.3	5.1
Percent Appeals Involving New Information[13]	83.5	83.0	82.8
Percent of Appeals Denied	62.8	61.8	61.8
Percent of Appeals Approved	36.9	37.8	37.8

Summary of Survey Results - Litigation Frequency and Costs – Short-term Disability Claims

	2012	2013	2014
Percent of Claims Litigated	*[14]	*[15]	0.01
Percent of Litigated Claims Upheld	16.2	17.9	19.8
Percent of Litigated Claims Overturned	6.8	2.6	3.8
Percent of Litigated Claims Settled	73.5	67.9	67.9

[11] *Id.* At 92334.
[12] Includes new information submitted by claimant and/or developed by insurance carrier.
[13] Includes new information submitted by claimant and/or developed by insurance carrier.
[14] 2012 and 2013 data on the percent of claims litigated are unavailable because litigation data was collected for the years 2012-2014 and claims data was collected for the years 2014-2016.
[15] *Id*.

Summary of Survey Results - Litigation Frequency and Costs – Long-term Disability Claims

	2012	2013	2014
Percent of Claims Litigated	*[16]	*[17]	0.4
Percent of Litigated Claims Upheld	6.3	6.3	6.3
Percent of Litigated Claims Overturned	3.3	2.0	1.8
Percent of Litigated Claims Settled	82.5	82.2	78.8

Estimated Start-Up Costs to Conform with Final Rule: $19.2 million

Estimated Total Annual Additional Labor Costs to Conform with Final Rule: $32.9 million

Percent of Companies Expecting Lawsuits to Increase as a Result of Final Rule: 100

Estimated Annual Percentage Increase in Litigation: 39

Estimated Annual Increase in Litigation Cost: $31.6 million

Estimated Elasticity Impact: ACLI's survey indicates that for each 1 percent increase in the price of disability coverage, the number of covered lives is expected to decrease by 1.9%.

II. The Department Should Repeal the Final Rule and Consider Regulatory Alternatives

A. The Vast Majority of Disability Claims are Paid Upon Initial Adjudication

In estimating long-term disability claim denial rates, the Department relied upon the 75 percent of denied claims for the Social Security Disability Insurance Program.[18] The Department noted, however, that using the SSDI denied claims rate as a proxy for the ERISA-covered plan claims denial rate may overstate the number of private-long-term disability plan denied claims. ACLI's data illustrates the extent of this overstatement and illustrates that the overwhelming majority of carrier DI claims are approved upon initial review. Based on ACLI's survey data, in 2016, 67.5 percent of long-term disability claims were approved upon initial review. Further, of those claims denied upon initial review, the majority were denied for reasons other than a determination that the claimant was not disabled - for example, the claimant was not covered or eligible for benefits under the terms of the plan, or failed to provide necessary information to substantiate their claim. Further, based on ACLI's survey, in 2016, 85.8% of short-term disability claims were approved during initial adjudication. These statistics overwhelmingly rebut any erroneous impression that most disability claims are denied, and indeed, illustrate that the majority of short-term and long-term disability claims are approved upon initial review. We urge the Department to use the 90-day extension to fully re-examine its rationale for promulgating the Final Rule, given that ACLI's survey disputes many of the premises and conclusions the Department relied upon during the rulemaking process.

[16] *Id.*
[17] *Id.*
[18] 81 Fed. Reg. at 92336.

B. The Final Rule Will Harm Disability Claimants

Significantly, the amended regulations will result in prolonged, arduous and labor-intensive disability claim processing, delayed claim decisions, and premature and lengthy litigation unduly focused on alleged procedural issues, none of which serve the interests of disability claimants. Based on our survey, with respect to short-term disability claims, the Final Rule will increase the average number of days to make an initial claims determination by 3.3 days and will increase the number of days to make a final appeals decision by 35.5 days. With respect to long-term disability claims, the Final Rule will increase the average number of days to make an initial claims determination by 6.9 days and will increase the number of days to make a final appeals decision by 47.3 days. Further, based upon the statistics we have compiled from our survey it is highly likely that the amended regulations will increase the cost of disability coverage. Based on our survey, the estimated total additional annual labor costs associated with the Final Rule will be $32.9 million. Increased costs will either be passed on to employees, or employers will choose to reduce or discontinue disability income insurance altogether.[19] The demand for employer-sponsored disability insurance is highly elastic and, accordingly, minor price increases could have a significant negative impact on coverage. Based on our survey, for each 1% increase in price, the number of covered lives is expected to decrease by 1.9%.

In sum, the reason for amending the regulations was based upon several incorrect and false premises. Further, the Final Rule will have unintended adverse consequences that will not advance the interests of disability claimants. We believe that the amendments relating to the exhaustion of administrative remedies (29 CFR § 2560.503-1(l)(2)) as well as the right to review and respond to new information (29 CFR § 2560.503-1(h)(4)) should be rescinded. While the Final Rule, as a whole, is unnecessary and is unlikely to advance the Department's objectives, these two provisions are the most harmful to both plans and plan participants and are the most likely to increase administrative costs and litigation.

If the Department does determine that changes are needed, we provide suggested alternative revisions to the Final Rule that would improve the cost-benefit calculus.

C. The Department Should Appropriately Evaluate the Impact of the Amendments

In the preamble to the Final Rule, the Department refers to its "experience since 2000 with the section 503 Regulation…"[20], cites advancements in claims processing technology, and cites to a single article purporting to document the volume and constancy of litigation in disability income claims[21] as rationales for the Final Rule amendments. The ACLI contests the accuracy of the article, and in fact, the statistics provided by the ACLI contradict the premises and conclusions made by the

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[19] "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. Schoonejongen, 514 U.S. 73, 78 (1995).

[20] See 81 Fed. Reg. at 92316.

[21] See footnote 5 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 recession influenced the increase in litigation.

author. ACLI's survey data illustrates that, in 2014, just 0.05 percent of all disability claims decisions were litigated. In short, the cited rationales simply do not provide a valid basis for amending the disability income insurance claims regulations as proposed. The Department's "experience" with the regulations is not identified. In addition, the qualitative benefits were not identified or discussed, nor was the cost of the proposed regulations quantified, a long-standing prerequisite of Federal agency rulemaking.

Further, as we have noted in both our January 19, 2016 comment letter and our October 27, 2017 comment letter[22], the complexity of disability claims does not permit the "auto-adjudication" typical of the healthcare claim determination process. As such, technology advances that have expedited processing of healthcare claims (e.g., the update of ICD-10 codes to insurers and medical offices systems) do not apply to disability income claim adjudication. Finally, we disagree that the proposed regulations will decrease the number of potential litigated cases. To the contrary, ACLI's survey data reflects that many of the amendments virtually guarantee an increase in litigated claims.

III. ACLI's Specific Concerns with the Final Rule

ACLI maintains, and ACLI's survey demonstrates, that the basic assumptions and conclusions relied upon by the Department during the rulemaking process were flawed and incorrect. ACLI's data illustrates that (1) Existing safeguards are robust and properly designed for disability claims; (2) Certain provisions of the Final Rule will cause delays ultimately harmful to claimants; and (3) the Final Rule will increase administrative and litigation costs and adversely impact the affordability of disability coverage. Accordingly, the Department should repeal the Final Rule and determine if regulatory alternatives are necessary.

In the event that the Department determines to retain the Final Rule, we provide below our specific concerns with certain of the Final Rule's provisions and suggested recommendations for improvement.

A. Exhaustion of Administrative Remedies

Section 2560.503-1(l) pertaining to the exhaustion of administrative remedies entitles a claimant to file suit if the plan "fails to strictly adhere to all the requirements" before an appeal decision has been made and regardless of whether that decision would have been ultimately favorable to the claimant. This provides a perverse incentive to bring suit before the administrative process is completed even if the alleged procedural violation does not materially impact the claim. While lengthy and costly litigation is guaranteed if this section goes into effect, there is no such guarantee of any benefit to the claimant. To the contrary, prolonged litigation (including lengthy discovery disputes and arguments over whether the plan's failure was *de minimis*) guarantee that a claims decision (whether by the court or by the administrator on remand) will be substantially delayed.

ACLI's survey indicates that carriers anticipate a 39 percent increase in litigation as a result of this section, and that litigation costs will increase by $31.6 million annually. Thus, this amendment

[22] January 19, 2016 and October 27, 2017 ACLI comment letters attached in Exhibit B.

should be reviewed and rescinded. Maintaining 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 and speedy 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. "The process is of substantial benefit to reviewing courts, because it gives them a factual predicate upon which to proceed." Chorosevic v. MetLife Choices, 600 F.3d 934, 941 (8th Cir. 2010), further citations omitted.

The Final Regulation does not require the claimant to have any communication with the plan once the claimant believes a procedural violation occurred. Because many (and maybe most) procedural violations could be addressed through an interactive dialogue with the plan, it would make far more sense for the claimant to be required to seek resolution of the issue with the plan rather than being able to immediately proceed to file a lawsuit for any procedural violation regardless of impact.

Under the Final Rule, the *de minimis* violation exception applies if the alleged procedural violation:

- was *de minimis* and 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."

This will require courts 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" will 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?); and
- if discovery into other alleged violations will be permitted before the court decides if the case is ripe for adjudication.

Ultimately, much of the information required for this inquiry will not be found in the administrative record. Rather, it will result in expensive discovery disputes and prolonged motion practice to resolve the issue. This is inconsistent with the Department's litigation reduction goals. Additionally, because some of the elements in the 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 far too broad. 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.

All of these abovementioned questions are procedural issues that will inappropriately shift the focus of litigation from the important substantive issues regarding the claimant's qualification for disability benefits to procedural technicalities. Accordingly, this section should be eliminated. If, after its review, the Department continues to believe that such procedural amendments provide an actual, measurable benefit to the claimant (whom the rules are intended to help), we suggest the following alternative.

As an alternative approach, the ACLI recommends 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.[23] 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.*, Wilczynski v. Lumbermen's Mut. Cas. Co., 93 F. 3d 397 (7th Cir. 1996).

The ACLI suggests 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.*

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[23] 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).

The ACLI also seeks modification of the language in subsection (l)(2)(ii) which allows 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 its bases, if any, for asserting that the violation should not cause the administrative remedies available under the plan to be deemed exhausted."

We propose that claimants should be required to clearly identify the request described in subsection (l)(2)(ii) as a prerequisite to filing suit under ERISA Section 502. This requirement would allow a plan to know that there is an attempt to trigger this part of the Rule. 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. This would also promote the Department's goal of facilitating greater dialogue between claimants and the plan. Finally, 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 revisions to subsection (l) would undoubtedly lead to increased litigation. Allowing access to Federal Court on a claim of a lack of "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 changes to subsection (l) will bring about the exact harm that we believe the Department seeks to avoid and decrease, namely: increased litigation and delay in claims resolution.

B. Right to Review and Respond to New Information before Final Decision

The revisions to subsection(h), which provides for a right to review and respond, is another example of a change in which the costs far exceed the benefits. As noted above, the Department concluded that few plans base adverse benefit determinations on appeal on new evidence or rationales. ACLI's survey illustrates the opposite. With respect to short-term disability claims, in 2014, 87.3 percent of appealed cased involved new information, in 2015, 87.9 percent of appealed cases involved new information, and in 2016, 83.9 percent of appealed cases involved new information. The average volume of this new information was 66 pages. With respect to long-term disability claims, ACLI's survey shows that in 2014, 83.5 percent of appealed cased involved new information, in 2015, 83 percent of appealed cases involved new information, and in 2016, 82.8 percent of appealed cases involved new information. The average volume of this new information was 261.5 pages.

Under the pre-2017 version of the claims regulation, 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 claimant can appeal earlier if he/she so chooses and thus speed up the ultimate decision-making process. 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 right to bring suit under ERISA.

Taking all of that into account, numerous courts have recognized that a claimant does receive a full and fair review under the pre-2017 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, 524 F.3d 1241 (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) of the regulations are problematic for several reasons, including their ambiguity and the impracticality of their application to the prompt administration of disability claims. First, it remains unclear what is meant by "*new and additional evidence,"* and there are sure to be costly disputes over the meaning of this provision. Second, 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. Third, this is potentially exacerbated by the lack of clarity regarding whether the administrator will have enough time to properly review information received late in the appeal period. Claim administrators could be forced to make a decision based on an incomplete record or exceed the allowable time periods to do a complete review. Under the Final Rule, exceeding the time period is a procedural violation which will entitle the claimant to run to court as described above. On the other hand, a hurried decision made in order to avoid running afoul of the time limits for making a claim decision is contrary to the standard of a "full and fair review."

By way of example, plans could have to send claimants new or additional evidence before the plan may have determined whether or how that evidence may contribute to an adverse appeal decision; claimants could receive or provide 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 it 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 time it takes to decide the appeal and the costs of administration without any reasonable connection to decreasing litigation or improving the outcome of the decision.

The Department should rescind the amendments to these sections. If the Department, after its review, determines that these provisions require revision, we suggest the following alternatives.

We recommend that the Department revise "*new and additional information*" to read "*new and additional medical reviews, including Independent Medical Examination (IME) reports.*"

In addition, 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 amend the Final Rule to 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.

Thus, we recommend the following amended language for section (h)(4)(i):

> *(i) "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."*[24]

Finally, with regard to subsection 4(ii), 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 amended 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, 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*

[24] As mentioned above, the application of timeframes and tolling will ensure the appeal process moves along and does not become stalled. In addition, situations may 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.

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.

C. 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. 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 recommend that the Final Rule be amended to 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 Final Rule be clarified that it applies only to adverse benefit determinations. Lastly, the Final Rule should be clarified 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 Final Rule. Again, it seems that the Department is deferring to what 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 context of disability claims. We suggest removing the word "culturally" from the Final Rule so as to eliminate this ambiguity.

D. Contractual Limitation Period

The Department requested public comment on the statute of limitations in ERISA cases, and specifically notice of an ERISA plan's contractual limitations period. The ACLI continues to recommend that the final determination on appeal quote in full the applicable plan's contractual limitation provision. We believe that adopting the Final Rule in which the determination letter must identify a specific date for the expiration of the limitation period will ultimately create confusion for claimants. While this recommendation does not get to the Department's desire that a date certain is named, the Department's decision is not practically possible given the intersection of unique policy language referring to proof of loss and state law. 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. Thus, 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.

IV. The Department Should Revise Its Regulatory Impact Analysis (RIA) Based on the New Data It Receives from Stakeholders

Based on additional data provided by stakeholders, it is imperative that the Department conduct a full and thorough new Regulatory Impact Analysis to determine if the benefits of the Final Rule outweigh its costs.

In the Final Rule, the Department stated that it had quantified the costs where possible and provided a qualitative discussion of the benefits that are associated with the proposed regulations. However, the Final Rule is replete with references to the Department's lack of data, much of it critical, to this rulemaking. Further, the Department stated that comment letters did not provide data on the cost analysis. Indeed, in the proposed rule to extend the applicability date, the Department stated that it had requested data in April 2015 ("2015 NPRM")[25]; however, we note that it was not until May 2015 that the Department even added to its regulatory agenda that it would propose amendments to claims procedures regulations. Further, it was not until November 18, 2015 that the Department issued the proposed rule, and this proposal did not include a request for data nor did it refer to the "2015 NPRM" in its cost-benefit analysis of that proposed rule. Instead the Department basically utilized analysis completed specifically for the health claims procedures update several years earlier. The Department's lack of data is reflected in its flawed RIA. As stated in our January 19, 2016 comment letter and 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. The delay should provide time for the Department to appropriately review the data herein and submitted by other interested parties and conduct a meaningful and appropriate RIA based on the disability income industry and not the utilization of the 5+ year old analysis done for the group health plan regulation update.

A. The Department Failed to Consider 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.[26] The 2015 proposed rule and the Final Rule did not include any discussion of possible regulatory alternatives contemplated or considered by the Department. Nor did the Department provide any evidence or data to conclude that the current disability claims regulatory regime was inadequate and warranted the revision. The November 18, 2015 proposed rule and the Final Rule were silent to this requirement.

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[25] See 82 Fed. Reg. 47409, 47411 (October 12, 2017).
[26] See 58 Fed. Reg. 51735 (October 4, 1993), Section 1(a).

B. The Department's Cost-Benefit Analysis Was 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."[27] 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."[28] 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."[29] 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.[30]

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."[31] 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 on performing cost-benefit analysis in its Circular A-4[32], which identifies three fundamental elements to Federal agency rulemaking: (i) a statement of the need for the proposed regulation; (ii) discussion of alternative regulatory

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[27] Op-Ed, President Barack 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 13563, which set strict standards for cost-benefit analysis in federal agency rulemaking.
[28] 46 Fed. Reg. 13193, 13193 (February 17, 1981).
[29] Exec. Order No. 12866, 3 C.F.R. 638 (1993).
[30] 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 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").
[31] 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).
[32] 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.

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.[33]

In the preamble of the Final Rule, 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 Final Rule. As discussed below, we believe that the Department (1) failed to qualitatively describe the benefits of the Final Rule, and (2) failed to adequately quantify the primary costs associated with the Final Rule.

C. The Department Overestimated the Benefits of the Final Rule

In the preamble, the Department acknowledges that it "does not have sufficient data to quantify the benefits associated with the final regulations due to data limitations and the lack of effective measures."[34] However, much of the Department's qualitative analysis consisted of the Department's "expectations" of the benefits of the Final Rule. Indeed, the Department attempts to justify its promulgation of the Final Rule by alleging a large volume of litigation in the disability claims area[35] and the advancements in claims processing technology. Pursuant 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 Final Rule is 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 this regulatory action.

The Department states that it "expects" that the Final Rule will improve the procedural protections for workers who become disabled and make claims for disability benefits. The Department, however, provided no basis for this "expectation" and, indeed, failed 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 Final Rule 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 Final Rule requires additional disclosure and a right to

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[33] 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.

[34] 81 Fed. Reg. at 92333.

[35] As indicated in footnote 5, 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.

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 requested 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 Final Rule will result in an endless loop, thus not being beneficial to claimants, claim adjudicators, or employers. The fact that the Department disregarded this potential issue and the potential delay to claimants remains a concern.

As further justification for the Final Rule, the Department stated 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 provided no explanation or basis as to how the Final Rule 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? Or is this yet another deferral to the health claims processing that been the primary basis for the rule amendments?

Finally, the Department stated 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 pre-2017 regulatory scheme provided 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.

D. The Department Underestimated the Costs of the Final Rule

Lacking an analysis of the actual cost of the Final Rule, the Department chose instead to selectively focus on two less expensive and quantifiable costs of the regulation, namely (1) the cost of providing the claimant any new or additional evidence considered; and (2) the cost of providing notices of adverse benefit determinations in a culturally and linguistically appropriate manner. Otherwise, the Final Rule is replete with statement after statement that the Department had no data or sufficient data[36] and that commenters did not provide data.

The Final Rule 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, or a treating physician 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 costs associated with disability

[36] *See* 21 Fed. Reg. at 92333, 92334, 92335, 92336, 92338, 92339, 92340.

claims determinations. It will also place an undue burden on the Social Security Administration by requiring it to respond to voluminous requests for information about its disability 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 Final Rule. Instead, they deflect this omission by stating that the "commenter provided no alternative estimates or data supporting their assertions that the Department could use to revise its cost estimate."[37]

Additionally, the ACLI is concerned that the Department has underestimated the costs associated with the 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 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 failed 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.[38] 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, rather the Department states that commenters did not provide estimates.

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. The pre-2017 rules provide for such 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.

ACLI's data illustrates that many of the Department's conclusions in promulgating the Final Rule were incorrect, and after a full evaluation, the Department will conclude that the Final Rule's costs outweigh its benefits. The Final Rule will add to the costs and administrative burden for a claims administrator to reasonably and timely decide benefit claims and the Final Rule will increase - not decrease – the number of litigated disability cases, in contravention of the Department's goals stated in the preamble. Moreover, the Final Rule will prolong the time it takes for the courts to resolve disputes.

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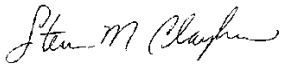
[37] 81 Fed. Reg. 92335.

[38] 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.

The Final Rule should be repealed. The Department should consider regulatory alternatives to reasonably address the Department's concerns through a more focused approach, as provided in this letter, that would not disrupt the careful balancing between ensuring fair and prompt enforcement of claimant rights under disability income plans and encouraging the creation and maintenance of such plans.

Sincerely,



Steven Clayburn, FSA, MAAA

Claims Procedure for Plans Providing Disability Benefits: RIN 1210-AB39 – ACLI Comment Letter

Exhibit A – ACLI Disability Income Insurance Carrier Survey: December 11, 2017

0A. What is your best estimate of the number of claims that, in the absence of the rule your company would deny, but will now approve solely because of the rule?

# of claims	0

0B. What is your best estimate of the annual benefits of the claims in question 0A?

# of claims	NA

1A. How many ERISA-qualified Group Disability Income policies were in force on Dec 31 of? I.e. The company has issued a policy and bears the actuarial risk. Do not include Administrative Services Only (ASO) plans.

	2014	2015	2016
# of Short-Term ONLY policies	77,218	163,796	130,179
# of Long-Term ONLY policies	79,466	163,812	133,548
# of policies covering both	83,954	158,698	139,196

1B. How many ERISA-qualified Group Disability plans did you act as administrator ONLY on Dec 31 of? I.e. An ASO plan where the insurance company has not issued a policy and therefore has no actuarial risk.

	2014	2015	2016
# of Short-Term ONLY plans	6,606	7,017	7,169
# of Long-Term ONLY plans	294	310	317
# of plans covering both	248	221	317

Note: If you sold a policy and act as administrator, the policy is recorded in 1A and nothing is recorded in 1B.

2A. How many covered lives were in the policies reported in 1A?

	2014	2015	2016
# in Short-Term ONLY	6,895,378	7,303,796	8,918,907
# in Long-Term ONLY	21,797,359	22,620,819	23,279,341
# in policies covering BOTH	30,375,822	31,469,327	31,090,625

2B. How many covered lives were in the plans reported in 1B?

	2014	2015	2016
# in Short-Term ONLY	9,595,102	10,198,394	10,427,363
# in Long-Term ONLY	468,070	474,115	336,357
# in plans covering BOTH	4,831,288	4,654,588	4,505,495

Short Term Disability Insurance Claims and Appeals

For this section, data should be based on year claim was received. For example, a claim received in 2015 regardless of when the disability was incurred, would be part of the 2015 data.

Claim counts should include both insured and ASO plans.

1. How many short-term disability income (STDI) claims were submitted initially?

	2014	2015	2016
# of claims submitted	1,917,745	2,009,803	2,077,288

2. Of the STDI initial claims, what number were:

	2014	2015	2016
Approved during the initial review	87.1%	86.2%	85.8%
Denied during the initial review	12.9%	13.8%	14.2%
Remain **unresolved**	0.0%	0.0%	0.0%

3. Of the STDI claims denied during the initial review, how many were due to the following
(If possible, please have column totals match denied claims from Q2)

	2014	2015	2016
Denied due to pre-existing condition	2.7%	2.9%	2.9%
Claimant not covered by policy/Not Eligible	19.6%	19.6%	18.9%
Death	0.4%	0.3%	0.3%
Information request not received	13.4%	14.4%	13.9%
Set up in error	3.3%	3.0%	3.6%
Not disabled any occupation	0.3%	0.2%	0.2%
Not disabled own occupation	18.1%	17.4%	16.9%
Policy exclusion	7.4%	7.6%	8.0%
RTW gainful occupation	0.0%	0.0%	0.0%
RTW own occupation	19.9%	17.9%	18.5%
Claimant withdrew claim	3.3%	4.1%	4.3%
Fraud	0.0%	0.1%	0.1%
Waiting period not satisfied	5.8%	6.4%	6.3%
All other reasons	5.8%	6.0%	6.2%

4. Among your STDI claims, what number of claimants were already approved for SSDI before your claims decision?

	2014	2015	2016
SSDI Approved	82	103	118

5. Of the claims in 4, what number of claims were initially denied?

	2014	2015	2016
# Denied	7	12	7

6. Of the claims in 5, how many were denied due to the following
(If possible, please have column totals match denied claims from Q5B)

	2014	2015	2016
Denied due to pre-existing condition	2	0	0
Claimant not covered by policy/Not Eligible	0	0	0
Death	0	0	0
Information request not received	2	0	0
Set up in error	0	0	0
Not disabled any occupation	0	0	2
Not disabled own occupation	0	0	2
Policy exclusion	0	2	0
RTW gainful occupation	0	0	0
RTW own occupation	0	0	0
Claimant withdrew claim	0	2	2
Fraud	0	0	0
Waiting period not satisfied	0	0	0
All other reasons	3	8	1

7. Please provide the average number of days involved in processing an initial STDI claim. Please count from when the claim is initially received to when initial decision is made.

	2014	2015	2016
All STD	13 days	13.3 days	13.5 days

8. What is your best estimate as to the number of days the rule will (decrease)/increase the number of days to make an initial claims decision?

3.3 days

9. Are individuals that review appeals compensated based on whether appeals are upheld or overturned?

Yes	0%
No	100%

10. Are your appeal staff members segregated from the claim staff making the initial claim denial?

Yes	100%
No	0%

<-- GO TO QUESTION 12

11. How are the appeal staff segregated from claim staff? (Mark all that apply)

Appeals are handled by a third-party	1%
Appeals staff do not make any initial claim decisions	100%
Appeals staff do not make initial claim decisions for that plan	37%

12. How many initially denied STDI claims were appealed? (Count multiple appeals of one claim as a single appeal)

	2014	2015	2016
Number appealed	11,925	13,574	16,148

13. How many appealed cases involved new information?

	2014	2015	2016
New info submitted by claimant	5.8%	3.2%	2.1%
New info developed by company	2.7%	2.8%	2.7%
New info submitted by BOTH	78.8%	81.8%	79.1%
No new info	12.7%	12.1%	16.1%

14. What is your best estimated of the <u>average</u> number of pages per appeal that this new information constitutes? (We acknowledge that "pages" is undefined. We are trying to determine the "volume" of new material.

Average pages per appeal	66.1 pages

Any comments on regarding the volume of new information?

15. How many of the appealed STDI claims were

	2014	2015	2016
Upheld with no new findings	57.2%	58.6%	58.5%
Upheld with new reason given for denial	4.9%	4.7%	4.1%
Overturned	37.9%	36.7%	37.0%
Settled	0.0%	0.1%	0.1%
Pending	0.0%	0.0%	0.3%

16. What was the average number of days involved in processing an STDI claim going through the entire appeal process. Please count from when the appeal was filed to final appeal decision. Exclude any claims in which the appeal has not been decided.

	2014	2015	2016
All appeals	42.8 days.	45.1 days.	40.5 days.

17. What is your best estimate as to the number of days the rule will (decrease)/increase the number of days to make a final appeals decision?

35.5 days

18. Do you allow a second or additional appeal?

Yes	42.4%
No	57.6%

19. Other than the first appeal, how many additional appeals do you allow?

(Select only 1)	
We only allow first level of appeal	47.2%
Second level	52.8%
Third level	0.0%
More than three levels	0.0%

20. What is the number of claimaints that ultimately will receive STDI benefits exclusively because of the rule? (I.e. Benefits would not have been paid except for the changes specified under the rule; please keep in mind that the rule does not change benefit qualification requirements?)

0

Long Term Disability Insurance Claims and Appeals

For this section, data should be based on year claim was received. For example, a claim received in 2015 regardless of when the disability was incurred, would be part of the 2015 data.

Claim counts should include both insured and ASO plans.

1. How many long-term disability income (LTDI) claims were submitted initially?

	2014	2015	2016
# of claims submitted	280,179	277,826	279,950

2. Of the LTDI initial claims, what number were:

	2014	2015	2016
Approved during the initial review	68.3%	68.1%	67.5%
Denied during the initial review	30.5%	30.8%	31.3%
Remain **unresolved**	1.2%	1.1%	1.2%

3. Of the LTDI claims denied during the initial review, how many were due to the following
(If possible, please have column totals match denied claims from Q2)

	2014	2015	2016
Denied due to pre-existing condition	6.5%	6.5%	6.4%
Claimant not covered by policy/Not Eligible	7.6%	7.6%	7.4%
Death	1.8%	1.7%	2.0%
Information request not received	14.9%	17.1%	18.5%
Set up in error	2.7%	2.7%	2.7%
Not disabled any occupation	0.4%	0.3%	0.3%
Not disabled own occupation	19.8%	19.6%	17.8%
Policy exclusion	1.9%	1.9%	2.8%
RTW gainful occupation	0.1%	0.1%	0.2%
RTW own occupation	19.1%	16.8%	15.2%
Claimant withdrew claim	4.8%	5.6%	6.1%
Fraud	0.0%	0.0%	0.0%
Waiting period not satisfied	15.2%	15.0%	15.9%
All other reasons	5.2%	5.1%	4.6%

4. Among your LTDI claims, what number of claimants were already approved for SSDI before your claims decision?

	2014	2015	2016
SSDI Approved	6,788	6,264	6,257

5. Of the claims in 4, what number of claims were initially denied?

	2014	2015	2016
# Denied	672	692	729

6. Of the claims in 5, how many were denied due to the following

(If possible, please have column totals match denied claims from Q5B)

	2014	2015	2016
74.2% Denied due to pre-existing condition	19.9%	18.8%	19.1%
Claimant not covered by policy/Not Eligible	8.9%	9.9%	5.9%
Death	3.6%	1.7%	2.2%
Information request not received	33.8%	35.2%	32.3%
Set up in error	0.6%	0.0%	2.6%
Not disabled any occupation	1.8%	4.5%	3.5%
Not disabled own occupation	15.0%	17.4%	17.4%
Policy exclusion	0.3%	0.0%	0.0%
RTW gainful occupation	0.0%	0.0%	0.0%
RTW own occupation	0.6%	0.0%	2.2%
Claimant withdrew claim	3.6%	4.5%	7.0%
Fraud	0.0%	0.0%	0.0%
Waiting period not satisfied	5.0%	5.7%	5.1%
All other reasons	6.8%	2.3%	2.6%

7. Please provide the average number of days involved in processing an initial LTDI claim. Please count from when the claim is initially received to when initial decision is made.

	2014	2015	2016
All LTD	39	39	39

8. What is your best estimate as to the number of days the rule will (decrease)/increase the number of days to make an initial claims decision?

6.9 days

9. Are individuals that review appeals compensated based on whether appeals are upheld or overturned?

Yes	0%
No	100%

10. Are your appeal staff members segregated from the claim staff making the initial claim denial?

Yes	100%
No	0%

<-- GO TO QUESTION 12

11. How are the appeal staff segregated from claim staff? (Mark all that apply)

Appeals are handled by a third-party	1%
Appeals staff do not make any initial claim decisions	100%
Appeals staff do not make initial claim decisions for that plan	42%

12. How many initially denied LTDI claims were appealed? (Count multiple appeals of one claim as a single appeal)

	2014	2015	2016
Number appealed	15,440	14,779	14,355

13. How many appealed cases involved new information?

	2014	2015	2016
New info submitted by claimant	1.1%	1.5%	1.1%
New info developed by company	1.1%	1.2%	0.9%
New info submitted by BOTH	81.3%	80.3%	80.9%
No new info	16.5%	17.0%	17.2%
Total Appeals	100.0%	100.0%	100.0%

14. What is your best estimated of the <u>average</u> number of pages per appeal that this new information constitutes? (We acknowledge that "pages" is undefined. We are trying to determine the "volume" of new material.

Average pages per appeal	261.5

Any comments on regarding the volume of new information?

15. How many of the appealed LTDI claims were

	2014	2015	2016
Upheld with no new findings	60.2%	59.2%	59.2%
Upheld with new reason given for denial	2.6%	2.7%	2.7%
Overturned	36.9%	37.8%	37.8%
Settled	0.3%	0.3%	0.3%
Pending	0.0%	0.1%	0.1%
	0.0%		

16. What was the average number of days involved in processing an LTDI claim going through the entire appeal process. Please count from when the appeal was filed to final appeal decision. Exclude any claims in which the appeal has not been decided.

	2014	2015	2016
All appeals	68.9 days	68.7 days	63.1 days

17. What is your best estimate as to the number of days the rule will (decrease)/increase the number of days to make a final appeals decision?

47.3 days

18. Do you allow a second or additional appeal?

Yes	51.8%
No	48.2%

19. Other than the first appeal, how many additional appeals do you allow?

(Select only 1)	
We only allow first level of appeal	41.5%
Second level	58.5%
Third level	0.0%
More than three levels	0.0%

20. What is the number of claimaints that ultimately will receive LTDI benefits exclusively because of the rule? (I.e. Benefits would not have been paid except for the changes specified under the rule; please keep in mind that the rule does not change benefit qualification requirements?)

0

Definition of Terms Used in the Survey

Denial: The determination, before any benefits are paid on a claim, that the claim is not valid.

Approval: The determination, before any benefits are paid on a claim, that the claim is valid.

Initial Review of the Claim: The process/procedure undertaken, prior to the denial or approval of a claim, as to whether the claim is valid

Initial Appeal: **Any** new review of the initial claims review that is made at the request of the claimant.

Termination of Benefit: Any claim which, having been deemed a valid claim and for which benefits have been paid, where benefits are terminated for any reason.

Claim Terminations, Combine STDI and LTDI

1. How many DI beneficiaries were receiving benefits at year end?

	2014	2015	2016
# of beneficiaries	698,196	711,444	712,491

2. How many claims were terminated?

	2014	2015	2016
# of terminations	1,816,926	1,888,461	1,941,331

3. What was the reason the claim was terminated

	2014	2015	2016
End of benefit period	15.5%	15.5%	15.6%
Fraud	0.0%	0.0%	0.0%
Beneficiary no longer disabled	53.9%	53.2%	52.3%
Death	1.7%	1.7%	1.7%
All other reasons	28.8%	29.6%	30.5%

4. How many of these terminations were disputed/appealed by the beneficiary?

	2014	2015	2016
# disputed/appealed?	41,121	40,504	41,938

5. What was the ultimate outcome of this dispute/appeal?

	2014	2015	2016
Termination upheld	62.5%	61.5%	62.9%
Termination overturned	34.6%	35.8%	33.6%
Final decision pending	0.0%	0.0%	0.8%
All other outcomes	2.9%	2.7%	2.7%

Litigation Frequency and Cost

1. Based on the year that the claim was filed. please indicate the number of claims that resulted in a lawsuit being filed that:

	STDI Lawsuits		
Note: Change in years requested	2012	2013	2014
Resulted in no change to company decision	19	14	21
Overturn any part of company decision	8	2	4
Were settled	86	53	72
Still pending	4	9	9

	LTDI Lawsuits		
Note: Change in years requested	2012	2013	2014
Resulted in no change to company decision	73	79	67
Overturn any part of company decision	38	25	19
Were settled	949	1025	843
Still pending	90	118	141

2. Among claims that result in litigation, what is the average litigation cost for your company?

$35,584

3. As a result of this rule, do you expect the number of lawsuits related to claims denials to:

Select only one		**Select only one**	
Decrease	0	% Decrease	0
No Change	0	No Change	NA
Increase	100%	% Increase	38%

Total Litigation Cost Increase $15,700,000

4. What is the basis for the prediction in question 3?

Select all that apply	
Internal Estimates	98%
Outside Consultants	31%
Other Sources	15%

5. Based on the year a termination-related lawsuit was filed, please indicate the number of lawsuits that ended with:

	2014	2015	2016
No change to company decision	83	63	65
Overturn any part of company decision	18	16	4
Were settled	1,380	1,110	650
Still pending	107	154	255

6. What is the average per termination litigation cost for your company?

$41,200

7. As a result of this rule, do you expect the number of lawsuits related to termination of benefits to:

Select only one		Select only one	
Decrease	0%	% Decrease	
No Change	0%	No Change	NA
Increase	100%	% Increase	40%

Total Litigation Cost Increase $15,946,000

8. What is the basis for the prediction in question 7?

Select all that apply	
Internal Estimates	97%
Outside Consultants	34%
Other Sources	0%

Other? Please describe

Internal Claim Procedures/Costs

Please provide your best estimate as to the following costs/expenses your company will incur due to the rule. Reasonable ballpark estimates are acceptable. This isn't rocket science but more akin to fishing with hand grenades -- close is great.

1. What is the estimated cost to update claim (and/or other) systems to comply with the rule? These are the start-up/implementation costs associated with ensuring that your systems and procedures will conform with the requirements of the rule. This would include legal advice, new computer hardware, leasing additional back office space, updating and testing computer software, employer training and so forth. It would not include the labor cost of additional staff, but would include the cost of training that staff.

$19,200,000

Briefly describe the systems and procedures that will need updating

2. The rule changes when customers may request the entire claims file. Briefly describe the types additional labor costs you anticipate incurring to conform to the rule?

3. Please provide your *best estimate* of the total additional annual labor costs (LTDI examiners, STDI examiners, Physicians, Nurses, adminstrative staff, etc) that your company will incur to conform with the proposed rule.

Administration Cost Increase	$32,900,000	
Litigation Cost Increase	$31,646,000	<--From litigation questions
Total Increase	$64,546,000	

Impact of 2000 Rule

The Department of Labor is seeking the following data as to the impact of the "2000 Final Rule": (1) cost increases that resulted from compliance with the 2000 Final Rule (or lack thereof) and whether such costs were passed on to consumers; (2) whether employers stopped offering disability insurance benefits and or employee take-up rates decreased, and (3) data that demonstrates how the 2000 Final Rule impacted the cost of disability claims litigation.

4. Does your company have reliable data that illuminates these three data requests?

No	100%	<-- Thank you
Yes		<--Thank you. ACLI will not be collecting nor aggregating this information. You may submit this information directly to the DOL.

Demand Elasticity of the Proposed Rule (2016 Rule)

5. Using your best estimate, please calculate the following ratio as to the impact of the 2016 proposed rule:
% Change in lives covered/% Change in Premium Price

-1.9	**I.e. For each 1% increase in price, 1.9% of customers will drop their coverage**

Note:
% change in lives covered = (Number of lives covered after rule – number of lives before rule)/(Lives before rule)
% change in premium price = (Price after rule – price before rule)/(Price before rule)

In October 2017 this survey, undertaken as a response to a Request for Information by the United States Department of Labor, was sent to group disability income insurers by the American Council of Insurers (ACLI). Survey questions were limited to only those disability income insurance policies and plans that were under the jurisdiction of the Employee Retirement Income and Security Act of 1974 (ERISA). Responses were received from companies representing over 80% of the lives insured under all group disability income insurance and included both ACLI member and non-member companies.

To ensure accuracy and consistency in responses, the survey instrument was developed by the ACLI Senior Economist Jeffry Janoska, PhD and disability income insurance experts within the industry. Survey results were collated and analyzed by Dr. Janoska.

In 1996, Dr. Janoska received his PhD from University of Maryland - College Park (UMCP). During his time at UMCP, Dr. Janoska worked at Clopper Almon's Interindustry Forecasting at the University of Maryland (INFORUM), a research institute specializing in forecasting the long-term economic impact of demographics and policy changes. Dr. Janoska's dissertation advisor was Clopper Almon. Dr. Janoska has worked at Economy.Com (nee RFA, Inc.) prior to joining ACLI. Dr. Janoska has served nearly twenty years at the ACLI and has developed an extensive knowledge base related to life insurer data, terminology and the most efficient methods to obtain consistent and accurate data when conducting industry surveys.

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

ACLI Comment Letter Exhibit B

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.

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[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

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[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]

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[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

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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

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[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

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[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.

Steven Clayburn, FSA, MAAA
Senior Actuary, Health Insurance & Reinsurance

October 27, 2017

Submitted Electronically via e-ORI@dol.gov

Office of Regulations and Interpretations
Employee Benefits Security Administration
Room N-5655
U.S. Department of Labor
200 Constitution Avenue NW.
Washington, DC 20210
Attention: Claims Procedure for Plans Providing Disability Benefits Examination

Subject: Claims Procedure for Plans Providing Disability Benefits; Extension of Applicability Date (RIN 1210-AB39)

Dear Sir/Madam:

On behalf of the American Council of Life Insurers[1] (ACLI), I appreciate the opportunity to provide comments in response to the proposal by the Department of Labor ("Department") to extend the January 1, 2018 applicability date of the final rule amending Section 2560.503-1 of the Employee Retirement Income Security Act ("ERISA"), the claims procedure regulations applicable to ERISA-covered employee benefit plans that provide disability income benefits (the "Final Rule") published on December 19, 2016.

ACLI strongly supports a delay of the applicability date. However, we are concerned that a 90-day delay will provide insufficient time for the Department to carefully review submitted data and comments, complete its examination, determine next steps, and communicate its conclusions to stakeholders in time for stakeholders to implement modifications to the Final Rule, if any. ACLI and its members have committed to work with the Department to gather data responsive to the data requests in the NPRM, and we have already begun this process. Given the volume and complexity of the data requested, the fact that our members utilize different systems, and the time required to review, analyze, and format the data in a responsive manner, we do not expect that we will be responding to the data request prior to the Department's December 11, 2017 deadline. Accordingly, we question whether a 90-day delay, through April 1, 2018, will provide sufficient time for the Department to review the data it has received, complete a new, updated Regulatory Impact Analysis ("RIA"), determine next steps, and obtain other required executive branch regulatory approval. Since disability claims administration is heavily dependent on technology, the industry estimates that it will need at least 180 days after final action by the Department to implement modifications.

[1] The American Council of Life Insurers (ACLI) is a Washington, D.C.-based trade association with approximately 290 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 95 percent of industry assets, 93 percent of life insurance premiums, and 98 percent of annuity considerations in the United States.

A Delay Will Provide Adequate Time for the Department to Evaluate the Impact of the Amendments

The ACLI agrees that the full and fair equitable administration of disability income claims is an important objective. However, as detailed in our January 19, 2016 comment letter, we have significant concerns with many provisions of the Final Rule. These provisions will increase the administrative burden on insurers and other claims administrators without any tangible benefit to claimants as to the fair and equitable adjudication of claims. Contrary to the expressed justification for the Final Rule, some of the final changes will unnecessarily complicate claims adjudication practices that have been working well for administrators and that have provided fair and equitable claims adjudication for claimants for over a decade.

In promulgating the Final Rule, the Department failed both to qualitatively describe the benefits of the proposed regulations, and to adequately quantify the proposed regulations' costs, a long-standing prerequisite of Federal agency rulemaking. Moreover, the Department also failed to adequately address the negative impact to consumers of the Final Rule. By way of illustration, the Final Rule's "new rationale" provisions will in most circumstances shorten the amount of time consumers will have to appeal a new rationale for denying their claim, which consequently may deprive them of the right to obtain a full and fair review. Additionally, the Final Rule's exhaustion of administrative remedies requirements will prolong the litigation between parties and will also likely increase the total number of benefit suits that are filed – in contravention to the Final Rule's stated goals. It is clear that the Department did not fully evaluate the negative impact of the Final Rule on consumers, and it is necessary and appropriate for the Department to therefore delay the applicability date to provide time for it to do so, as well as time for the Department to review and consider the critical information the Department is now seeking.

A Delay Will Provide Adequate Time for the Department to Evaluate the Significant Differences in Disability Income Insurance Adjudication versus Medical Expense Insurance Adjudication

As further detailed in our January 19th comment letter, the Department, in promulgating the Final Rule, stated that it intended to amend ERISA disability claims regulations to mirror health insurance claims procedures under the Affordable Care Act. However, in doing so, the Department failed to recognize the material differences inherent in how disability income claims are adjudicated versus adjudication of medical claims. The fundamental differences between medical and disability claims adjudication are material to the impact of the Final Rule. 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 review of data from multiple sources of information and the skilled input of many types of professionals, including medical, vocational, and rehabilitation specialists. Disability claims involve a higher degree of analysis and require more extensive, time-consuming, and ongoing reviews (as a claim can last years or decades). Disability claims administrators are required to take into consideration the 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, among other items. Moreover, the adjudicating of a disability claim is not a binary decision. The medical, occupational, and other information that comes into a claim file is constantly evolving and must be examined holistically and repeatedly by the claim examiner as the medical condition of a claimant evolves over time. In addition, many disability plans contain definitions of disability that change over the pendency of a claim, typically from "own occupation" to "any occupation" as defined in the plan to continue to receive disability

benefits, adding further to the complexity of the claim administration. These are just some of the ways that disability claims adjudication differs from medical claims adjudication, which is a far simpler process. The current disability claims regulations take these differences into account. The Final Rule does not do so in every instance. Regulations that may well serve medical claimants will not work for disability income claimants.

It is precisely these distinctions that led to the claims procedure regulations being promulgated with separate requirements for health care and disability income plans seventeen years ago, a distinction that serves the interests of all stakeholders and thus should continue, with appropriate amendments. A delay will provide time for all parties to gain a clearer understanding of the differences in claims adjudication.

A Delay Will Provide Adequate Time for the Department to Revise the Regulatory Impact Analysis

In the Final Rule, the Department stated that it had quantified the costs where possible and provided a qualitative discussion of the benefits that are associated with the proposed regulations. However, the Final Rule is replete with references to the Department's lack of data, much of it critical, to this rulemaking. Further, the Department stated that comment letters did not provide data on the cost analysis. Indeed, in the proposed rule to extend the applicability date, the Department stated that it had requested data in April 2015 ("2015 NPRM")[2]; however, we note that it was not until May 2015 that the Department even added to its regulatory agenda that it would propose amendments to claims procedures regulations. Further, it was not until November 18, 2015 that the Department issued the proposed rule, and this proposal did not include a request for data nor did it refer to the "2015 NPRM" in its cost/benefit analysis of that proposed rule. Instead the Department basically utilized analysis completed specifically for the health claims procedures update several years earlier. The Department's lack of data is reflected in its flawed RIA. As stated in our January 19th comment letter, 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. A delay at this point will provide time for the Department to review the data it requested on October 12, 2017, and conduct a meaningful and appropriate RIA.

Summary

All claimants are entitled to a full and fair review. The pre-January 1, 2017 rules provide for such full and fair review. The Final Rule will add to the costs and administrative burden for a claims administrator to reasonably and timely decide benefit claims and the Final Rule will increase - not decrease – the number of litigated disability cases, in contravention of the Department's goals stated in the preamble. Moreover, it will prolong the time it takes for the courts to resolve disputes.

ACLI strongly supports the proposal to delay the applicability date of the disability claims procedures rule for further review. In addition, ACLI will respond with data and comments pertinent for a meaningful and an appropriate examination of the merit of review of potential regulatory alternatives by the December 11, 2017 deadline.

Sincerely,

Steven Clayburn, FSA, MAAA

[2] See 82 Fed. Reg. 47409, 47411 (October 12, 2017)