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DEPARTMENT OF LABOR

Employee Benefits Security Administration

29 CFR Part 2560

RIN 1210-AB39

Claims Procedure for Plans Providing Disability Benefits

AGENCY: Employee Benefits Security Administration, Department of Labor.

ACTION: Notice of proposed rulemaking.

SUMMARY: This document contains proposed amendments to claims procedure regulations for plans providing disability benefits under the Employee Retirement Income Security Act of 1974 (ERISA). The amendments would revise and strengthen the current rules primarily by adopting certain of the new procedural protections and safeguards made applicable to group health plans by the Affordable Care Act. If adopted as final, the proposed regulation would affect plan administrators and participants and beneficiaries of plans providing disability benefits, and others who assist in the provision of these benefits, such as third-party benefits administrators and other service providers that provide benefits to participants and beneficiaries of these plans.

DATES: Written comments should be received by the Department of Labor on or before [INSERT DATE THAT IS 60 DAYS AFTER PUBLICATION IN THE FEDERAL REGISTER].

ADDRESSES: You may submit written comments, identified by RIN 1210-AB39, by one of the following methods:

- *Federal eRulemaking Portal:* <http://www.regulations.gov>. Follow the instructions for submitting comments.
- *Email:* e-ORI@dol.gov. Include RIN 1210-AB39 in the subject line of the message.

- *Mail:* 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 Regulation Amendment for Plans Providing Disability Benefits.

Instructions: All submissions received must include the agency name and Regulatory Identifier Number (RIN) for this rulemaking. All comments will be available to the public, without charge, online at <http://www.regulations.gov> and <http://www.dol.gov/ebsa>, and at the Public Disclosure Room, Employee Benefits Security Administration, Suite N-1513, 200 Constitution Avenue, NW, Washington, DC 20210.

WARNING: Do not include any personally identifiable or confidential business information that you do not want publicly disclosed. All comments are posted on the Internet exactly as received, and can be retrieved by most internet search engines. No deletions, modifications, or redactions will be made to the comments received, as they are public records.

FOR FURTHER INFORMATION CONTACT: Frances P. Steen, Office of Regulations and Interpretations, Employee Benefits Security Administration, (202) 693-8500. This is not a toll free number.

SUPPLEMENTARY INFORMATION:

A. Executive Summary

In accordance with Executive Order 13563, this section of the preamble contains an executive summary of the proposed rulemaking in order to promote public understanding and to ensure an open exchange of information and perspectives. Sections B through E of this preamble, below, contain a more detailed description of the regulatory provisions and need for the rulemaking, as well as its costs and benefits.

1. *Purpose of Regulatory Action*

The purpose of this action is to improve the current procedural protections for workers who become disabled and make claims for disability benefits from an employee benefit plan. ERISA requires that plans provide claimants with written notice of benefit denials and an opportunity for a full and fair review of the denial by an appropriate plan fiduciary. The current regulations governing the processing of claims and appeals were published 15 years ago. Because of the volume and constancy of litigation in this area, and in light of advancements in claims processing technology, the Department recognizes a need to revisit, reexamine, and revise the current regulations in order to ensure that disability benefit claimants receive a fair review of denied claims as provided by law. To this end, the Department has determined to start by proposing to uplift the current standards applicable to the processing of claims and appeals for disability benefits so that they better align with the requirements regarding internal claims and appeals for group health plans under the regulations implementing the requirements of the Affordable Care Act.¹ Inasmuch as disability and lost earnings can be sources of severe hardship for many individuals, the Department thinks that disability benefit 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.

2. *Summary of Major Provisions*

The major provisions in the proposal largely adopt the procedural protections for health care claimants in the Affordable Care Act, including provisions that seek to ensure that: (1) claims and appeals are adjudicated in manner designed to ensure independence and impartiality

¹ The Patient Protection and Affordable Care Act, Public Law 111-148, was enacted on March 23, 2010, and the Health Care and Education Reconciliation Act, Public Law 111-152, was enacted on March 30, 2010. (These statutes are collectively known as the “Affordable Care Act.”)

of the persons involved in making the decision; (2) benefit denial notices contain a full discussion of why the plan denied the claim and the standards behind the decision; (3) claimants have access to their entire claim file and are allowed to present evidence and testimony during the review process; (4) claimants are notified of and have an opportunity to respond to any new evidence reasonably in advance of an appeal decision; (5) final denials at the appeals stage are not based on new or additional rationales unless claimants first are given notice and a fair opportunity to respond; (6) if plans do not adhere to all claims processing rules, the claimant is deemed to have exhausted the administrative remedies available under the plan, unless the violation was the result of a minor error and other specified conditions are met; (7) certain rescissions of coverage are treated as adverse benefit determinations, thereby triggering the plan's appeals procedures; and (8) notices are written in a culturally and linguistically appropriate manner.

3. Costs and Benefits

The Department expects that these proposed regulations would improve the procedural protections for workers who become disabled and make claims for disability benefits from employee benefit plans. This would cause some participants to receive benefits they might otherwise have been incorrectly denied absent the fuller protections provided by the proposed regulations. In other circumstances, 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. 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 among individual plans.

The Department expects the proposed regulations would impose modest costs on disability benefit plans, because many plans already are familiar with the rules that would apply to disability benefit claims due to their current application to group health plans. As discussed in detail in the cost section below, the Department quantified the costs associated with two provisions of the proposed regulations: the requirement to provide additional information to claimants in the appeals process (\$1.9 million annually) and the requirement to provide information in a culturally and linguistically appropriate manner (\$1.1 million annually).

B. Background

1. *Section 503 of ERISA and the Section 503 Regulations*

Section 503 of ERISA requires every employee benefit plan, in accordance with regulations of the Department, to “provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant” and to “afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.”

In 1977, the Department published a regulation pursuant to section 503, at 29 CFR 2560.503-1, establishing minimum requirements for benefit claims procedures for employee benefit plans covered by title I of ERISA (hereinafter “Section 503 Regulation”).² The Department revised and updated the Section 503 Regulation in 2000 by improving and strengthening the minimum requirements for employee benefit plan claims procedures under

² 42 FR 27426 (May 27, 1977).

section 503 of ERISA.³ As revised in 2000, the Section 503 Regulation provided new time frames and enhanced requirements for notices and disclosure with respect to decisions at both the initial claims decision stage and on review. Although the Section 503 Regulation applies to all covered employee benefit plans, including pension plans, group health plans, and plans that provide disability benefits, the more stringent procedural protections apply to group health plans and to claims with respect to disability benefits.⁴

2. The Affordable Care Act Additions to the Section 503 Regulations

Section 715(a)(1) of ERISA, added by the Affordable Care Act, provides that certain provisions of the Public Health Service Act (PHS Act) apply to group health plans and health insurance issuers in connection with providing health insurance coverage as if the provisions were included ERISA . Such provisions include section 2719 of the PHS Act which addresses among other items internal claims and appeals and processes for group health plans and health insurance issuers. Section 2719 of the PHS Act provides that group health plans must have in effect an internal claims and appeals process and that such plans must initially incorporate the claims and appeals processes set forth in the Section 503 Regulation and update such processes in accordance with standards established by the Secretary of Labor.

On July 23, 2010, the Departments of Health and Human Services, Labor, and the Treasury (collectively the Departments) issued interim final regulations implementing PHS Act

³ 65 FR 70246 (Nov. 21, 2000), amended at 66 FR 35887 (July 9, 2001).

⁴ A benefit is a disability benefit, subject to the special rules for disability claims under the Section 503 Regulation, if the plan conditions its availability to the claimant upon a showing of disability. It does not matter how the benefit is characterized by the plan or whether the plan as a whole is a pension plan or a welfare plan. If the claims adjudicator must make a determination of disability in order to decide a claim, the claim must be treated as a disability claim for purposes of the Section 503 Regulation. See FAQs About The Benefit Claims Procedure Regulation, A-9 (http://www.dol.gov/ebsa/faqs/faq_claims_proc_reg.html).

section 2719 and issued amendments to the IFR on June 24, 2011 (hereinafter “the 2719 IFR”).⁵ The 2719 IFR updated the Section 503 Regulation to ensure that non-grandfathered group health plans implement an effective internal claims and appeal process, in compliance with the Affordable Care Act.⁶

Elsewhere in today’s version of the **Federal Register**, the Departments published final regulations implementing section PHS Act section 2719 (regarding internal claims and appeals and external review processes) and PHS Act 2712 (regarding restrictions on rescissions) (collectively “the 2719 Final Rule”). The 2719 Final Rule implements the requirements regarding internal claims and appeals and external review processes for group health plans and health insurance coverage in the group and individual markets under the Affordable Care Act.

The 2719 Final Rule adopts and clarifies the new requirements in the 2719 IFR that apply to internal claims and appeals processes for non-grandfathered group health plans.

3. *Substantial Litigation*

Even though fewer private-sector employees participate in disability plans than in other types of plans,⁷ disability cases dominate the ERISA litigation landscape today.⁸ An aging American workforce may likely be a contributing factor to the significant volume of disability cases. Aging workers initiate more disability claims, as the prevalence of disability increases

⁵ See 75 FR 37188 (June 28, 2010), 75 FR 43330 (July 23, 2010) and 76 FR 37208 (June 24, 2011).

⁶ The requirements of the Affordable Care Act and the 2719 IFR do not apply to grandfathered health plans under section 1251 of the Affordable Care Act. The Department in conjunction with the Department of Health and Human Services and the Department of the Treasury published interim final regulations implementing section 1251 of the Affordable Care Act. See 75 FR 34538 (June 17, 2010) and 75 FR 70114 (Nov. 17, 2010). Elsewhere in today’s version of the **Federal Register**, the Departments published final regulations implementing section 1251 of the Affordable Care Act.

⁷ BLS National Compensation Survey, March 2014, at <http://www.bls.gov/ncs/ebs/benefits/2014/ebb10055.pdf>.

⁸ See Sean M. Anderson, *ERISA Benefits Litigation: An Empirical Picture*, 28 ABA J. Lab. & Emp. L. 1 (2012).

with age.⁹ And as a result, insurers and plans looking to contain disability benefit costs are often motivated to aggressively dispute disability claims. This aggressive posture coupled with the inherently factual nature of disability claims highlight for the Department the need to review and strengthen the procedural rules governing the adjudication of disability benefit claims.

4. *ERISA Advisory Council Recommendations*

In 2012, the ERISA Advisory Council undertook a study on issues relating to managing disability in an environment of individual responsibility. The Advisory Council issued a report containing, in relevant part, recommendations for review of the Section 503 Regulation to determine updates and modifications for disability benefit claims, drawing upon analogous processes described in the 2719 IFR where appropriate, to address (1) what is an adequate opportunity to develop the record; and (2) content for denials of such claims.¹⁰

Based on the foregoing, the Department believes that in order to afford claimants of disability benefits a reasonable opportunity to pursue a full and fair review, as required by ERISA section 503, modifications to the Section 503 Regulation, that align with the updated standards required by the Affordable Care Act and extended to non-grandfathered group health plans in paragraph (b) of the 2719 Final Rule at 29 CFR 2590.715-2719, are necessary.

C. Overview of Proposed Regulation

1. *Independence and Impartiality – Avoiding Conflicts of Interest*

In order to ensure a full and fair review of claims and appeals, the Section 503 Regulation already contains certain standards of independence for persons making claims decisions, and the proposal would build on these standards by providing new criteria for avoiding conflicts of

⁹ See Francine M. Tishman, Sara Van Looy, & Susanne M. Bruyere, Employer Strategies for Responding to an Aging Workforce, NTAR Leadership Center (2012).

¹⁰ The report may be accessed at <http://www.dol.gov/ebsa/publications/2012ACreport2.html>.

interest. In alignment with criteria in the 2719 Final Rule, paragraph (b)(7) of the proposal explicitly provides that plans providing disability benefits would have to “ensure that all disability benefit claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision.” The proposal also would require that decisions regarding hiring, compensation, termination, promotion, or similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support the denial of disability benefits. For example, a plan would not be permitted to provide bonuses based on the number of denials made by a claims adjudicator. Similarly, a plan would not be permitted to contract with a medical expert based on the expert’s reputation for outcomes in contested cases, rather than based on the expert’s professional qualifications. These added criteria address practices and behavior which, in the context of disability benefits, the Department finds difficult to reconcile with the “full and fair review” guarantee in section 503 of ERISA and which are questionable under ERISA’s basic fiduciary standards.

2. Improvements to Basic Disclosure Requirements

The proposal would amend the current disclosure requirements in three significant respects. First, adverse benefit determinations on disability benefit claims would have to contain a discussion of the decision, including the basis for disagreeing with any disability determination by the Social Security Administration (SSA), by a treating physician, or other third party disability payor, to the extent that the plan did not follow those determinations presented by the claimant. This provision would address the confusion often experienced by claimants when

there is little or no explanation provided for their plan's determination and/or their plan's determination is contrary to their doctor's opinion or their SSA award of disability benefits.¹¹

Second, adverse benefit determinations would have to contain the internal rules, guidelines, protocols, standards or other similar criteria of the plan that were used in denying the claim (or a statement that these do not exist). Third, a notice of adverse benefit determination at the claim stage would have to contain a statement that the claimant is entitled to receive, upon request, relevant documents. Under the current Section 503 Regulation, such statement is required only in notices of an adverse benefit determination denied on appeal.

These provisions would serve the purpose of ensuring that claimants fully understand why their disability benefit claim was denied so they are able to meaningfully evaluate the merits of pursuing an appeal.¹² As described below, paragraph (p) of the proposal incorporates the provision from the 2719 Final Rule that requires notices to be written in a culturally and linguistically appropriate manner.

3. Right to Review and Respond to New Information Before Final Decision

The proposal would add criteria to ensure a full and fair review of denied disability claims by explicitly providing that claimants have a right to review and respond to new evidence

¹¹ See, e.g., McDonough v. Aetna Life Ins. Co., 783 F.3d 374, 382 (1st Cir. 2015) (holding that "Aetna's failure to articulate the contours of the own occupation standard, apply that standard in a meaningful way, and reason from that standard to an appropriate conclusion regarding the appellant's putative disability renders its benefits-termination decision arbitrary and capricious."). See also Montour v. Hartford Life and Accident Ins. Co., 588 F.3d 623, 637 (9th Cir. 2009) ("Hartford's failure to explain why it reached a different conclusion than the SSA is yet another factor to consider in reviewing the administrator's decision for abuse of discretion, particularly where, as here, a plan administrator operating with a conflict of interest requires a claimant to apply and then benefits financially from the SSA's disability finding.").

¹² See, e.g., Bard v. Boston Shipping Ass'n., 471 F.3d 229, 240 (1st Cir. 2006) ("in relying on the McLaughlin arbitration to reject Bard's claim, the Board relied on a rule, guideline, protocol, or other similar criterion[,] [y]et Bard was not notified of even a condensed version of this rule, nor does it appear that he was timely notified that the McLaughlin arbitrator's opinion existed at all.") (internal quotation and citation omitted); Salomaa v. Honda Long Term Disability Plan, 642 F.3d 666, 679 (9th Cir. 2011) ("The review was not 'fair,' as the statute requires, because the plan did not give Salomaa and his attorney and physicians access to the two medical reports of its own physicians upon which it relied, among other reasons. In addition, the plan administrator denied the claim largely on account of absence of objective medical evidence, yet failed to tell Salomaa what medical evidence it wanted.").

or rationales developed by the plan during the pendency of the appeal, as opposed merely to having a right to such information on request only after the claim has already been denied on appeal, as some courts have held under the Section 503 Regulation. Specifically, the proposal provides that prior to a plan's decision on appeal, a disability benefit claimant must be provided, free of charge, with any new or additional evidence considered, relied upon, or generated by (or at the direction of) the plan in connection with the claim, as well as any new or additional rationale for a denial, and a reasonable opportunity for the claimant to respond to such new or additional evidence or rationale. See paragraph (h)(4)(i)-(iii) of the proposal. Although these important protections are direct imports from the 2719 Final Rule, they would correct procedural problems evidenced in the litigation even predating the ACA.¹³ It is the view of the Department that claimants are deprived of a full and fair review, as required by section 503 of ERISA, when they are prevented from responding at the administrative stage level to evidence and rationales.¹⁴ Accordingly, adding these provisions to the Section 503 Regulation would explicitly address this problem and redress the procedural wrongs evidenced in the litigation under the current regulation.

As an example of how these new provisions would work, assume the plan denies a claim at the initial stage based on a medical report generated by the plan administrator. Also assume the claimant appeals the adverse benefit determination and, during the 45-day period the plan has to make its decision on appeal, the plan administrator causes a new medical report to be

¹³ See, e.g., Metzger v. Unum Life Ins. Co. of America, 476 F.3d 1161, 1165-67 (10th Cir. 2007) (holding that “subsection (h)(2)(iii) does not require a plan administrator to provide a claimant with access to the medical opinion reports of appeal-level reviewers prior to a final decision on appeal.”). Accord Glazer v. Reliance Standard Life Ins. Co., 524 F.3d 1241 (11th Cir. 2008); Midgett v. Washington Group Int’l Long Term Disability Plan, 561 F.3d 887 (8th Cir. 2009).

¹⁴ Brief of the Secretary of Labor, Hilda L. Solis, as Amicus Curiae in Support of Plaintiff-Appellant’s Petition for Rehearing, Midgett v. Washington Group Int’l Long Term Disability Plan, 561 F.3d 887 (8th Cir. 2009) (No. 08-2523).

generated by a medical specialist who was not involved with developing the first medical report. The proposal would require the plan to automatically furnish to the claimant any new evidence in the second report. The plan would have to furnish the new evidence to the claimant before the expiration of the 45-day period. The evidence would have to be furnished as soon as possible and sufficiently in advance of the applicable deadline (including an extension if available) in order to give the claimant a reasonable opportunity to respond to the new evidence. The plan would be required to consider any response from the claimant. If the claimant's response happened to cause the plan to generate a third medical report containing new evidence, the plan would have to automatically furnish to the claimant any new evidence in the third report. The new evidence would have to be furnished as soon as possible and sufficiently in advance of the applicable deadline to allow the claimant a reasonable opportunity to respond to the new evidence in the third report.

The right of disability benefit claimants to review new evidence or new rationales is a less meaningful right standing by itself than if accompanied by a right to respond to the new information. Consequently, the proposal would also grant the claimant a right to respond to the new information by explicitly providing claimants the right to present evidence and written testimony as part of the claims and appeals process. See paragraph (h)(4)(i) of the proposal.¹⁵

These new rights (i.e., review and response rights) are being proposed as an overlay to the detailed timing rules already in the Section 503 Regulation. In particular, the Section 503 Regulation already contains timing rules for disability claims that allow plan administrators extensions “for special circumstances” at the appeals stage, with a related tolling provision if the

¹⁵ Consistent with paragraph (h)(2)(ii) of the Section 503 Regulation (granting claimants the right to “submit written comments, documents, records, and other information relating to the claim for benefits”), paragraph (h)(4)(i) of the proposal contemplates written evidence and testimony and therefore, in the Department's view, does not entitle the claimant to an oral hearing.

reason for an extension is “due to a claimant’s failure to submit information necessary to decide a claim.” See 29 CFR 2560.503-1(i)(3)(i) and (i)(4). Comments are requested on whether, and to what extent, modifications to the existing timing rules are needed to ensure that disability benefit claimants and plans will have ample time to engage in the back-and-forth dialog that is contemplated by the new review and response rights.

For instance, is a special tolling rule like the one adopted today for group health plans under the 2719 Final Rule also needed for disability benefit appeals? The 2719 Final Rule, in relevant part, provides “if the new or additional evidence is received so late that it would be impossible to provide it to the claimant in time for the claimant to have a reasonable opportunity to respond, the period for providing a notice of final internal adverse benefit determination is tolled until such time as the claimant has a reasonable opportunity to respond. After the claimant responds, or has a reasonable opportunity to respond but fails to do so, the plan or issuer must notify the claimant of the benefit determination as soon as a plan or issuer acting in a reasonable and prompt fashion can provide the notice, taking into account the medical exigencies.” See 29 CFR 2590.715-2719(b)(2)(ii)(C)(2). The proposal does not adopt this tolling provision from the 2719 Final Rule because, as noted above, the existing Section 503 Regulation already permits plans providing disability benefits to take extensions at the appeals stage. This special tolling provision under the 2719 Final Rule was needed for group health plans because the Section 503 Regulation generally does not permit them to take extensions at the appeals stage.

4. Deemed Exhaustion of Claims and Appeals Processes

The proposal would strengthen the deemed exhaustion provision in the Section 503 Regulation in three important respects. First, the more stringent standards in the 2719 Final Rule would replace existing standards for disability benefit claims in cases where the plan fails to

adhere to all the requirements of the Section 503 Regulation. Thus, in this respect, the proposal would adopt the 2719 Final Rule's approach, including an exception in paragraph (1)(2)(ii) for errors that are minor and meet certain other specified conditions. Second, in those situations when the minor errors exception does not apply, the proposal clarifies that the reviewing tribunal should not give special deference to the plan's decision, but rather should review the dispute de novo. Third, protection would be given to claimants whose attempts to pursue remedies in court under section 502(a) of ERISA based on deemed exhaustion are rejected by a reviewing tribunal.¹⁶

The minor errors exception would operate as follows. The proposal would provide that any violation of the procedural rules in the Section 503 Regulation would permit a claimant to seek immediate court action, unless the violation was: (i) de minimis; (ii) non-prejudicial; (iii) attributable to good cause or matters beyond the plan's control; (iv) in the context of an ongoing good-faith exchange of information; and (v) not reflective of a pattern or practice of non-compliance. In addition, the claimant would be entitled upon request, to an explanation of the plan's basis for asserting that it meets this standard, so that claimant could make an informed judgment about whether to seek immediate review.

Too often claimants find themselves without any forum to resolve their disputes if they prematurely pursued their claims in court before exhausting the plan's administrative remedies. To prevent this from happening to disability benefit claimants even more frequently due to the interplay between the strict compliance standard and the minor errors exception, the proposal contains a special safeguard for claimants who erroneously concluded their plan's violation of

¹⁶ The deemed exhaustion provision in the proposal, if adopted in a final regulation, would supersede any and all prior Departmental guidance with respect to disability benefit claims to the extent such guidance is contrary to the final regulation, including but not limited to FAQ F-2 in Frequently Asked Questions About The Benefit Claims Procedure Regulation (http://www.dol.gov/ebsa/faqs/faq_claims_proc_reg.html).

the Section 503 Regulation entitled them to take their claim directly to court. The safeguard provides that if a court rejects the claimant's request for immediate review on the basis that the plan met the standards for the minor errors exception, the claim would be considered as re-filed on appeal upon the plan's receipt of the decision of the court. In addition, within a reasonable time after the receipt of the decision, the plan would be required to provide the claimant with notice of the resubmission. At this point, the claimant would have the right to pursue the claim in accordance with the plan's provisions governing appeals, including the right to present evidence and testimony.

The proposed standards set forth the Department's view of the consequences that ensue when a plan fails to provide procedures for disability benefit claims that meet the requirements of section 503 of ERISA as set forth in regulations. They reflect the Department's view that if the plan fails to provide processes that meet the regulatory minimum standards, and does not otherwise qualify for the minor errors exception, the disability benefit claimant should be free to pursue the remedies available under section 502(a) of ERISA on the basis that the plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim. The Department's intentions in including this provision in the proposal are to clarify that the procedural minimums of the Section 503 Regulation are essential to procedural fairness and that a decision made in the absence of the mandated procedural protections should not be entitled to any judicial deference. In this regard, the proposal provides that if a claimant chooses to pursue remedies under section 502(a) of ERISA under such circumstances, the claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary. Consequently, rather than giving special deference to the plan, the reviewing court should review the dispute *de novo*.

5. *Coverage Rescissions – Adverse Benefit Determinations*

The proposal would add a new provision to address coverage rescissions not already covered under the Section 503 Regulation. For this purpose, a rescission generally is a cancellation or discontinuance of disability coverage that has retroactive effect. The Section 503 Regulation already covers a rescission if the rescission is the basis, in whole or in part, of an adverse benefit determination. For instance, if a plan were to deny a claim based on a conclusion that the claimant is ineligible for benefits due to a rescission of coverage, the claimant would have a right to appeal the adverse benefit determination under the plan's procedures for reviewing denied claims. Other rescissions (those made in the absence of a claim, such as resulting from an internal audit), however, may not be covered by the Section 503 Regulation and, consequently, would not trigger the procedural protections of section 503 of ERISA. Although many rescissions may be proper under the terms of the plan, some rescissions may be improper or erroneous. In the latter case, participants and beneficiaries may face dangerous and unwanted lapses in disability coverage without their knowledge, and without knowing how to challenge the rescission.

Accordingly, the proposed rule would amend the definition of an adverse benefit determination to include, for plans providing disability benefits, a rescission of disability benefit coverage that has a retroactive effect, whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time. Thus, for example, a rescission of disability benefit coverage would be an adverse benefit determination even if the affected participant or beneficiary was not receiving disability benefits at the time of the rescission. The specific amendment would expand the scope of the current definition by expressly providing that an "adverse benefit determination" includes a rescission of disability coverage with respect to a

participant or beneficiary, and define the term “rescission” to mean “a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.” This new definition is modeled on the definition of rescission in the 2719 Final Rule, but would not be limited to rescissions based upon fraud or intentional misrepresentation of material fact.¹⁷ Consequently, if a plan provides for a rescission of coverage for disability benefits if an individual makes a misrepresentation of material fact, even if the misrepresentation was not intentional or made knowingly, the rescission would be an adverse benefit determination under this proposal. This proposed change would not prohibit rescissions; rather, it would require plans to treat certain rescissions as adverse benefit determinations, thereby triggering the applicable procedural rights under the Section 503 Regulation.

6. *Culturally & Linguistically Appropriate Notices*

The proposal contains safeguards for individuals who are not fluent in English. The safeguards would require that adverse benefit determinations with respect to disability benefits be provided in a culturally and linguistically appropriate manner in certain situations. The safeguards include standards that illustrate what would be considered “culturally and linguistically appropriate” in these situations. The safeguards and standards are incorporated directly from the 2719 Final Rule and reflect public comment on that rule. The relevant standards are contained in paragraph (p) of the proposal.

Under the proposed safeguards, if a claimant’s address is in a county where 10 percent or more of the population residing in that county, as determined based on American Community

¹⁷ The Affordable Care Act prohibits group health plans from rescinding coverage with respect to an individual once the individual is covered, except in the case of fraud or intentional misrepresentation of material fact. Consequently, the definition of adverse benefit determination in the 2719 Final Rule effectively is limited to these situations. See 75 FR 37188 and 75 FR 43330.

Survey (ACS) data published by the United States Census Bureau, are literate only in the same non-English language, notices of adverse benefit determinations to the claimant would have to include a prominent one-sentence statement in the relevant non-English language about the availability of language services.¹⁸ In addition, the plan would be required to provide a customer assistance process (such as a telephone hotline) with oral language services in the non-English language and provide written notices in the non-English language upon request. Oral language services includes answering questions in any applicable non-English language and providing assistance with filing claims and appeals in any applicable non-English language.

Two hundred and fifty-five (255) U.S. counties (78 of which are in Puerto Rico) meet the 10 percent threshold at the time of this proposal. The overwhelming majority of these are Spanish; however, Chinese, Tagalog, and Navajo are present in a few counties, affecting five states (specifically, Alaska, Arizona, California, New Mexico, and Utah). A full list of the affected U.S. counties is available on the Department's website and updated annually.¹⁹

D. Miscellaneous

1. *Technical Correction*

The Department has determined that a minor technical fix to the Section 503 Regulation is required with respect to disability claims. The Department proposes to clarify that the extended time frames for deciding disability claims, provided by the quarterly meeting rule found in the current regulation at 29 CFR 2560.503-1(i)(1)(ii), are applicable only to multiemployer plans. Accordingly, the proposal would amend paragraph (i)(3) to correctly refer to the appropriate subparagraph in (i)(1) of the Section 503 Regulation.

¹⁸ The Department provides sample sentences in Model Notices at www.dol.gov/ebsa/healthreform/regulations/internalclaimsandappeals.html.

¹⁹ <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/2009-13-CLAS-County-Data.pdf>.

2. *Request for Comments - Statute of Limitations*

ERISA does not specify the period after a final adverse benefit determination within which a civil action must be filed under section 502(a)(1)(B) of ERISA. Instead, the federal courts have generally looked to analogous state laws to determine an appropriate limitations period. Analogous state law limitations periods vary, but they generally start with the same event, the plan's final benefit determination. Plan documents and insurance contracts sometimes have limitations periods which may override analogous state laws. These contractual limitations periods are not uniform and the events that trigger their running vary. In addition, claimants may not have read the relevant plan documents or the documents may be difficult for claimants to understand. The Supreme Court recently upheld the use of contractual limitations periods so long as they are reasonable.²⁰

A separate issue, not before the Supreme Court in Heimeshoff v. Hartford Life & Accident Ins. Co., is whether plans should provide participants with notice with respect to contractual limitations periods in adverse benefit determinations on review. The courts of appeals are currently in disagreement on whether plans should provide such notice under the Section 503 Regulation.²¹ Inasmuch as plans are responsible for implementing contractual limitations provisions, plans may be in a better position than claimants to understand and to

²⁰ Heimeshoff v. Hartford Life & Accident Ins. Co., 134 S.Ct. 604, 611 (2013).

²¹ Compare Moyer v. Metropolitan Life Ins. Co., 762 F.3d 503, 505 (6th Cir. 2014) ("The claimant's right to bring a civil action is expressly included as a part of those procedures for which applicable time limits must be provided" in the notice of adverse benefit determination on review) with Wilson v. Standard Ins. Co., 613 F. App'x 841, 844 n.3 (11th Cir. 2015) (per curiam) ("We are not persuaded by the Sixth Circuit's conclusion that a claims administrator's interpretation of the ambiguous § 2560.503-1(g)(1)(iv) not to require notice in the claim denial letter of the contractual time limit for judicial review necessarily amounts to a failure to comply with § 1133 that renders the contractual limitations provision unenforceable.").

explain what those provisions mean.²² In addition, it could prove costly to a participant to hire a lawyer to provide an interpretation that should be readily available to the plan at little or no cost. Accordingly, the Department solicits comments on whether the final regulation should require plans to provide claimants with a clear and prominent statement of any applicable contractual limitations period and its expiration date for the claim at issue in the final notice of adverse benefit determination on appeal and with an updated notice of that expiration date if tolling or some other event causes that date to change.

E. Effective Date

The Department proposes to make this regulation effective 60 days after the date of publication of the final rule in the Federal Register.

F. Economic Impact and Paperwork Burden

1. *Background and Need for Regulatory Action*

As discussed in Section B of this preamble, the proposed amendments would revise and strengthen the current rules regarding claims and appeals applicable to ERISA-covered plans providing disability benefits primarily by adopting several of the new procedural protections and safeguards made applicable to ERISA-covered group health plans by the Affordable Care Act. Before the enactment of the Affordable Care Act, group health plan sponsors and sponsors of ERISA-covered plans providing disability benefits were required to implement claims and appeal processes that complied with the Section 503 Regulation. The enactment of the ACA and the issuance of the implementing interim final regulations resulted in disability benefit claimants

²² *Cf. Moyer*, 762 F.3d at 507 ("The exclusion of the judicial review time limits from the adverse benefit determination letter was inconsistent with ensuring a fair opportunity for review and rendered the letter not in substantial compliance.")

receiving fewer procedural protections than group health plan participants even though litigation regarding disability benefit claims is prevalent today.

The Department believes this action is necessary to ensure that disability claimants receive the more stringent procedural protections that Congress and the President established for group health care claimants under the Affordable Care Act. This will result in some participants receiving benefits they might otherwise have been incorrectly denied in the absence of the fuller protections provided by the proposed regulation. This will help alleviate the financial and emotional hardship suffered by many individuals when they lose earnings due to their becoming disabled. The proposed rule also should help limit the volume and constancy of disability benefits litigation.

The Department has crafted these proposed regulations to secure the protections of those submitting disability benefit claims. In accordance with OMB Circular A-4, the Department has quantified the costs where possible and provided a qualitative discussion of the benefits that are associated with these proposed regulations.

2. Executive Order 12866 and 13563--Department of Labor

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects; distributive impacts; and equity). Executive Order 13563 emphasizes the importance of quantifying both costs and benefits, of reducing costs, of harmonizing rules, and of promoting flexibility.

Under Executive Order 12866 (58 FR 51735), “significant” regulatory actions are subject to review by the Office of Management and Budget (OMB). Section 3(f) of the Executive Order

defines a “significant regulatory action” as an action that is likely to result in a rule (1) having an annual effect on the economy of \$100 million or more in any one year, or adversely and materially affecting a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local or tribal governments or communities (also referred to as “economically significant”); (2) creating a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in the Executive Order. It has been determined that this rule is significant within the meaning of section 3(f) (4) of the Executive Order. Therefore, OMB has reviewed these proposed rules pursuant to the Executive Order. The Department provides an assessment of the potential costs and benefits of proposed rule below, as summarized in Table 1, below.

Table 1-- *Accounting Table*

Category	Estimate	Year Dollar	Discount Rate	Period Covered
Benefits - Qualitative	The Department expects that these proposed regulations would improve the procedural protections for workers who become disabled and make claims for disability benefits from employee benefit plans. This would cause some participants to receive benefits they might otherwise have been incorrectly denied absent the fuller protections provided by the proposed regulations. In other circumstances, 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. 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 among individual plans.			
Costs				
Annualized	\$3,019,000	2015	7%	2016-2025
Monetized	\$3,019,000	2015	3%	2016-2025

Qualitative	These requirements would impose modest costs on plan, because many plans already are familiar with the rules that would apply to disability benefit claims due to their current application to group health plans. As discussed in detail in the cost section below, the Department quantified the costs associated with two provisions of the proposed regulations: the requirement to provide additional information to claimants in the appeals process and the requirement to provide information in a culturally and linguistically appropriate manner.
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3. Estimated Number of Affected Entities

The Department does not have complete data on the number of plans providing disability benefits or the total number of participants covered by such plans. All ERISA-covered welfare benefit plans with more than 100 participants are required to file a Form 5500. Only some ERISA-covered welfare benefit plans with less than 100 participants are required to file for various reasons, but this number is very small. Based on current trends in the establishment of pension and health plans, there are many more small plans than large plans, but the majority of participants are covered by the large plans.

Data from the 2013 Form 5500 indicates that there are 34,300 plans covering 52.2 million participants reporting a code indicating they provide temporary disability benefits, and 26,400 plans covering 46.9 million participants reporting a code indicating they provide long-term disability benefits. To put these numbers in perspective, using the CPS and the MEPS-IC, the Department estimates that there are 140,000 large group health plans and 2.2 million small group health plans.

4. Benefits

In developing these proposed regulations, the Department closely considered their potential economic effects, including both benefits and costs. The Department does not have sufficient data to quantify the benefits associated with these proposed regulations due to data limitations and a lack of effective measures. Therefore, the Department provides a qualitative discussion of the benefits below.

These proposed regulations would implement a more uniform and rigorous system of disability claims and appeals processing that conforms to the rules applicable to group health plans. In general, the Department expects that these proposed regulations would improve the procedural protections for workers who become disabled and make claims for disability benefits from employee benefit plans. This will cause some participants to receive benefits that, absent the fuller protections of the regulation, they might otherwise have been incorrectly denied. In other circumstances, expenditures by plans may be reduced as a fuller and fairer system of claims and appeals processing helps facilitate participant acceptance of cost management efforts. 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 among individual plans. This certainty and consistency can also be expected to benefit, to varying degrees, all parties within the system and to lead to broader social welfare gains, particularly for participants.

The Department expects that these proposed regulations also will improve the efficiency of plans providing disability benefits by enhancing their transparency and fostering participants' confidence in their fairness. The enhanced disclosure and notice requirements of these proposed regulations would benefit participants and beneficiaries better understand the reasons underlying adverse benefit determinations and their appeal rights.

For example, the proposed regulations would require adverse benefit determinations to contain a discussion of the decision, including the basis for disagreeing with any disability determination by the Social Security Administration (SSA), a treating physician, or other third party disability determinations, to the extent that the plan did not follow those determinations

presented by the claimant. This provision would address the confusion often experienced by claimants when there is little or no explanation provided for their plan's determination and/or their plan's determination is contrary to their doctor's opinion or their SSA award of disability benefits.

Under the proposal, adverse benefit determinations would have to contain the internal rules, guidelines, protocols, standards or other similar criteria of the plan that were used in denying the claim (or a statement that these do not exist), and a notice of adverse benefit determination at the claim stage would have to contain a statement that the claimant is entitled to receive, upon request, relevant documents. These provisions would benefit claimants by ensuring that they fully understand why their claim was denied so they are able to meaningfully evaluate the merits of pursuing an appeal.

The proposal also would require adverse benefit determinations for certain participants and beneficiaries that are not fluent in English to be provided in a culturally and linguistically appropriate manner in certain situations. Specifically, if a claimant's address is in a county where 10 percent or more of the population residing in that county, as determined based on American Community Survey (ACS) data published by the United States Census Bureau, are literate only in the same non-English language, notices of adverse benefit determinations to the claimant would have to include a prominent one-sentence statement in the relevant non-English language about the availability of language services. This provision would ensure that certain disability claimants that are not fluent in English understand the notices received from the plan regarding their disability claims and their right to appeal denied claims. The proposal also would provide claimants with the right to review and respond to new evidence or rationales developed by the plan during the pendency of the appeal, as opposed merely to having a right to such

information on request only after the claim has already been denied on appeal, as some courts have held under the current regulation. Specifically, the proposal provides that prior to a plan's decision on appeal, a disability benefit claimant must be provided, free of charge, with new or additional evidence considered, relied upon, or generated by (or at the direction of) the plan in connection with the claim, as well as any new or additional rationale for a denial, and a reasonable opportunity for the claimant to respond to such new or additional evidence or rationale. These important protections would benefit participants and beneficiaries by correcting procedural wrongs evidenced in the litigation even predating the ACA.

The voluntary nature of the employment-based benefit system in conjunction with the open and dynamic character of labor markets make explicit as well as implicit negotiations on compensation a key determinant of the prevalence of employee benefits coverage. The prevalence of benefits is therefore largely dependent on the efficacy of this exchange. If workers perceive that there is the potential for inappropriate denial of benefits or handling of appeals, they will discount the value of such benefits to adjust for this risk. This discount drives a wedge in compensation negotiation, limiting its efficiency. With workers unwilling to bear the full cost of the benefit, fewer benefits will be provided. To the extent that workers perceive that these proposed regulations, supported by enforcement authority, reduces the risk of inappropriate denials of disability benefits, the differential between the employers' costs and workers' willingness to accept wage offsets is minimized.

These proposed regulations would reduce the likelihood of inappropriate benefit denials by requiring all disability claims and appeals to be adjudicated by persons that are independent and impartial. Specifically, the proposal would prohibit hiring, compensation, termination, promotion, or other similar decisions with respect to any individual (such as a claims adjudicator

or medical expert) to be made based upon the likelihood that the individual will support the plan's benefits denial. This would enhance participants' perception that their disability plan's claims and appeals processes are operated in a fair manner.

The proposal would add criteria to ensure a full and fair review of denied claims by making it explicitly clear that claimants have a right to review and respond to new evidence or rationales developed by the plan during the pendency of the appeal rather than only after the claim has already been denied on appeal, as some courts have held under the current regulation. Specifically, the proposal would require a disability benefit claimant to be provided, free of charge, with new or additional evidence considered, relied upon, or generated by (or at the direction of) the plan in connection with the claim, as well as any new or additional rationale for a denial, and a reasonable opportunity for the claimant to respond to such new or additional evidence or rationale before issuing an adverse benefit determination on review.

Providing a more formally sanctioned framework for adjudicating disability claims and appeals facilitates the adoption of cost containment programs by employers who, in the absence of a regulation providing some guidance, may have opted to pay questionable claims rather than risk alienating participants or being deemed to have breached their fiduciary duty.

In summary, the proposed rules provide more uniform standards for handling disability benefit claims and appeals that are comparable to the rules applicable to group health plans. These rules would reduce the incidence of inappropriate denials, averting serious financial hardship and emotional distress for participants and beneficiaries that are impacted by a disability. They also would enhance participants' confidence in the fairness of their plans' claims and appeals processes. Finally, by improving the transparency and flow of information between plans and claimants, the proposed regulations would enhance the efficiency of labor and

insurance markets. The Department therefore concludes that the economic benefits of these proposed regulations will justify their costs.

5. Costs and Transfers

The Department has quantified the primary costs associated with these proposed regulations' requirements to (1) provide the claimant free of charge with any new or additional evidence considered, and (2) to providing notices of adverse benefit determinations in a culturally and linguistically appropriate manner. These requirements and their associated costs are discussed below.

Provision of new or additional evidence or rationale: As stated earlier in this preamble, before a plan providing disability benefits can issue a notice of adverse benefit determination on review on a disability benefit claim, these proposed regulations would require such plans to provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by (or at the direction of) the plan as soon as possible and sufficiently in advance of the date the notice of adverse benefit determination on review is required to be provided and any new or additional rationale sufficiently in advance of the due date of the response to an adverse benefit determination on review. This requirement increases the administrative burden on plans to prepare and deliver the enhanced information to claimants. The Department is not aware of data suggesting how often plans rely on new or additional evidence or rationale during the appeals process or the volume of materials that are received.

For purposes of this regulatory impact analysis, the Department assumes, as an upper bound, that all appealed claims will involve a reliance on additional evidence or rationale. The Department assumes that this requirement will impose an annual aggregate cost of \$1.9 million. The Department estimated this cost by assuming that compliance will require medical office

staff, or other similar staff in other service setting with a labor rate of \$30, five minutes²³ to collect and distribute the additional evidence considered, relied upon, or generated by (or at the direction of) the plan during the appeals process. The Department estimates that on average, material, printing and postage costs will total \$2.50 per mailing. The Department further assumes that 75 percent of all mailings will be distributed electronically with no associated material, printing or postage costs.²⁴

The Department lacks data on the number of disability claims that are filed or denied. Therefore, the Department estimates the number of short- and long-term disability claims based on the percentage of private sector employees (119 million)²⁵ that participate in short- and long-term disability programs (approximately 39 and 33 percent respectively).²⁶ The Department estimates the number of claims per covered life for long-term disability benefits based on the percentage of covered individuals that file claims under the Social Security Disability Insurance Program (two percent of covered individuals). The Department does not have sufficient data to estimate the percentage of covered individuals that file short-term disability claims. Therefore, for purposes of this analysis, the Department estimates of six percent of covered lives file such claims, because it believes that short-term disability claims rates are higher than long-term disability claim rates.

²³ The Department's estimated 2015 hourly labor rates include wages, other benefits, and overhead are calculated as follows: mean wage from the 2013 National Occupational Employment Survey (April 2014, Bureau of Labor Statistics http://www.bls.gov/news.release/archives/ocwage_04012014.pdf); wages as a percent of total compensation from the Employer Cost for Employee Compensation (June 2014, Bureau of Labor Statistics http://www.bls.gov/news.release/archives/ecec_09102014.pdf); overhead as a multiple of compensation is assumed to be 25 percent of total compensation for paraprofessionals, 20 percent of compensation for clerical, and 35 percent of compensation for professional; annual inflation assumed to be 2.3 percent annual growth of total labor cost since 2013 (Employment Costs Index data for private industry, September 2014 http://www.bls.gov/news.release/archives/eci_10312014.pdf).

²⁴ This estimate is based on the methodology used to analyze the cost burden for the Section 503 Regulation (OMB Control Number 1210-0053).

²⁵ BLS Employment, Hours, and Earnings from the Current Employment Statistics survey (National) Table B-1.

²⁶ "Beyond the Numbers: Disability Insurance Plans Trends in Employee Access and Employer Cost," February 2015 Vol. 4 No. 4. <http://www.bls.gov/opub/btn/volume-4/disability-insurance-plans.htm>.

The Department estimates the number of denied claims that would be covered by the rule in the following manner: For long-term disability, the percent of claims denied is estimated using the percent of denied claims for the Social Security Disability Insurance Program (75 percent). For short-term disability, the estimate of denied claims (three percent) is from the 2012 National Compensation Survey: Employee Benefits in Private Industry in the United States. The estimates are provided in the table below.

Table 2--Fair and Full Review Burden (in thousands)

	Short-Term		Long-Term		Total		
	Electronic	Paper	Electronic	Paper	Electronic	Paper	All
Denied Claims and lost Appeals with Additional Information	63	21	463	154	526	175	701
Mailing cost per event	\$0.00	\$0.99	\$0.00	\$0.99	\$0.00	\$0.99	
Total Mailing Cost	\$0.00	\$21	\$0.00	\$153	\$0.00	\$173	\$173
Preparation Cost per event	\$2.50	\$2.50	\$2.50	\$2.50	\$2.50	\$2.50	\$2.50
Total Preparation cost	\$157	\$52	\$1,156	\$385	\$1,313	\$438	\$1,751
Total	\$157	\$73	\$1,156	\$538	\$1,313	\$611	\$1,925

Providing Notices in a Culturally and Linguistically Appropriate Manner: The proposed regulations would require notices of adverse benefit determinations with respect to disability benefits to be provided in a culturally and linguistically appropriate manner in certain situations. This requirement is satisfied if plans provide oral language services including answering questions and providing assistance with filing claims and appeals in any applicable non-English language. These proposed regulations also require each notice sent by a plan to which the requirement applies to include a one-sentence statement in the relevant non-English that translation services are available. Plans also must provide, upon request, a notice in any applicable non-English language.

The Department expects that the largest cost associated with the requirement for culturally and linguistically appropriate notices will be for plans to provide notices in the

applicable non-English language upon request. Based on the 2013 ACS data, the Department estimates that there are about 11.4 million individuals living in covered counties that are literate in a non-English Language.²⁷ To estimate the number of the 11.4 million individuals that might make a request, the Department estimates the number of workers in each state with access to short-term and long-term disability insurance (total population in county* state labor force participation rate* state employment rate).^{28,29} The number of employed workers then was multiplied by an estimate of the share of workers participating in disability benefits, 39 percent for short-term and 33 percent for long term disability.³⁰

In discussions with the regulated community, the Department found that experience in California, which has a State law requirement for providing translation services, indicates that requests for translations of written documents averages 0.098 requests per 1,000 members for health claims. While the California law is not identical to these proposed regulations, and the demographics for California do not match other counties, for purposes of this analysis, the Department uses this percentage to estimate of the number of translation service requests that plans could expect to receive. As there are fewer disability claims than health claims, the Department believes that this estimate significantly overstates the cost. Industry experts also told the Department that while the cost of translation services varies, \$500 per document is a reasonable approximation of translation cost.

²⁷ <http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/2009-13-CLAS-County-Data.pdf>
<http://www.dol.gov/ebsa/pdf/coveragebulletin2014.pdf> Table 1C.

²⁸ Labor force Participation rate: <http://www.bls.gov/lau/staadata.txt> Unemployment rate:
<http://www.bls.gov/lau/lastrk14.htm>.

²⁹ Please note that using state estimates of labor participation rates and unemployment rates could lead to an over estimate as those reporting in the ACS survey that they speak English less than “very well” are less likely to be employed.

³⁰ "Beyond the Numbers: Disability Insurance Plans Trends in Employee Access and Employer Cost," February 2015 Vol. 4 No. 4. <http://www.bls.gov/opub/btn/volume-4/disability-insurance-plans.htm>.

Based on the foregoing, the Department estimates that the cost to provide translation services will be approximately \$1.1 million annually (23,206,000 lives * 0.098/1000 * \$500).

6. Regulatory Flexibility Act--Department of Labor and Department of Health and Human Services

The Regulatory Flexibility Act (5 U.S.C. 601 et seq.) (RFA) imposes certain requirements with respect to Federal rules that are subject to the notice and comment requirements of section 553(b) of the Administrative Procedure Act (5 U.S.C. 551 et seq.) and which are likely to have a significant economic impact on a substantial number of small entities. Unless an agency determines that a proposal is not likely to have a significant economic impact on a substantial number of small entities, section 603 of the RFA requires the agency to present an initial regulatory flexibility analysis (IRFA) of the proposed rule. The Department's IRFA of the proposed rule is provided below.

Need for and Objectives of the Rule: As discussed in section B of this preamble, the proposed amendments would revise and strengthen the current rules regarding claims and appeals applicable to ERISA-covered plans providing disability benefits primarily by adopting several of the new procedural protections and safeguards made applicable to ERISA-covered group health plans by the Affordable Care Act. Before the enactment of the Affordable Care Act, group health plan sponsors and sponsors of ERISA-covered plans providing disability benefits were required to implement internal claims and appeal processes that complied with the Section 503 Regulation. The enactment of the Affordable Care Act and the issuance of the implementing interim final regulations resulted in disability plan claimants receiving fewer procedural protections than group health plan participants even though litigation regarding disability benefit claims is prevalent today.

The Department believes this action is necessary to ensure that disability claimants receive the same protections that Congress and the President established for group health care claimants under the Affordable Care Act. This will result in some participants receiving benefits they might otherwise have been incorrectly denied in the absence of the fuller protections provided by the proposed regulation. This will help alleviate the financial and emotional hardship suffered by many individuals when they lose earnings due to their becoming disabled. The proposed rule also should help limit the volume and constancy of disability benefits litigation.

Affected Small Entities: The Department does not have complete data on the number of plans providing disability benefits or the total number of participants covered by such plans. All ERISA-covered welfare benefit plans with more than 100 participants are required to file a Form 5500. Only some ERISA-covered welfare benefit plans with less than 100 participants are required to file for various reasons, but this number is very small. Based on current trends in the establishment of pension and health plans, there are many more small plans than large plans, but the majority of participants are covered by the large plans.

Data from the 2013 Form 5500 indicates that there are 34,300 plans covering 52.2 million participants reporting a code indicating they provide temporary disability benefits, and 26,400 plans covering 46.9 million participants reporting a code indicating they provide long-term disability benefits. To put these numbers in perspective, using the CPS and the MEPS-IC, the Department estimates that there are 140,000 large group health plans and 2.2 million small group health plans.

Impact of the Rule: The Department has quantified the primary costs associated with these proposed regulations' requirements to (1) provide the claimant free of charge with any new

or additional evidence considered, and (2) to providing notices of adverse benefit determinations in a culturally and linguistically appropriate manner. These requirements and their associated costs are discussed in the Costs and Transfers section above.

Provision of new or additional evidence or rationale: As stated earlier in this preamble, before a plan can issue a notice of adverse benefit determination on review, these proposed regulations would require plans to provide disability benefit claimants, free of charge, with any new or additional evidence considered, relied upon, or generated by (or at the direction of) the plan as soon as possible and sufficiently in advance of the date the notice of adverse benefit determination on review is required to be provided and any new or additional rationale sufficiently in advance of the due date of the response to an adverse benefit determination on review.

The Department is not aware of data suggesting how often plans rely on new or additional evidence or rationale during the appeals process or the volume of materials that are received. The Department estimated the cost per claim by assuming that compliance will require medical office staff, or other similar staff in other service setting with a labor rate of \$30, five minutes³¹ to collect and distribute the additional evidence considered, relied upon, or generated by (or at the direction of) the plan during the appeals process. The Department estimates that on average, material, printing and postage costs will total \$2.50 per mailing. The Department

³¹ The Department's estimated 2015 hourly labor rates include wages, other benefits, and overhead are calculated as follows: mean wage from the 2013 National Occupational Employment Survey (April 2014, Bureau of Labor Statistics http://www.bls.gov/news.release/archives/ocwage_04012014.pdf); wages as a percent of total compensation from the Employer Cost for Employee Compensation (June 2014, Bureau of Labor Statistics http://www.bls.gov/news.release/archives/ecec_09102014.pdf); overhead as a multiple of compensation is assumed to be 25 percent of total compensation for paraprofessionals, 20 percent of compensation for clerical, and 35 percent of compensation for professional; annual inflation assumed to be 2.3 percent annual growth of total labor cost since 2013 (Employment Costs Index data for private industry, September 2014 http://www.bls.gov/news.release/archives/eci_10312014.pdf).

further assumes that 75 percent of all mailings will be distributed electronically with no associated material, printing or postage costs.

Providing Notices in a Culturally and Linguistically Appropriate Manner: The proposed regulations would require that notices of adverse benefit determinations with respect to disability benefits be provided in a culturally and linguistically appropriate manner in certain situations. This requirement is satisfied if plans provide oral language services including answering questions and providing assistance with filing claims and appeals in any applicable non-English language. These proposed regulations also require such notices of adverse benefit determinations sent by a plan to which the requirement applies to include a one-sentence statement in the relevant non-English language about the availability of language services. Plans also must provide, upon request, such notices of adverse benefit determinations in the applicable non-English language.

The Department expects that the largest cost associated with the requirement for culturally and linguistically appropriate notices will be for plans to provide notices in the applicable non-English language upon request. Industry experts also told the Department that while the cost of translation services varies, \$500 per document is a reasonable approximation of translation cost.

In discussions with the regulated community, the Department found that experience in California, which has a State law requirement for providing translation services, indicates that requests for translations of written documents averages 0.098 requests per 1,000 members for health claims. While the California law is not identical to these proposed regulations, and the demographics for California do not match other counties, for purposes of this analysis, the Department used this percentage to estimate of the number of translation service requests plans

could expect to receive. Based on the low number of requests per claim, the Department expects that translation costs would be included as part of a package of services offered to a plan, and that the costs of actual requests will be spread across multiple plans.

Duplication, Overlap, and Conflict with Other Rules and Regulations: The Department does not believe that the proposed actions would conflict with any relevant regulations, federal or other.

Based on the foregoing, the Department hereby certifies that these final regulations will not have a significant economic impact on a substantial number of small entities.

7. Paperwork Reduction Act

As part of its continuing effort to reduce paperwork and respondent burden, the Department conducts a preclearance consultation program to provide the general public and Federal agencies with an opportunity to comment on proposed and continuing collections of information in accordance with the Paperwork Reduction Act of 1995 (PRA)(44 U.S.C. 3506(c)(2)(A)). This helps to ensure that the public understands the Department's collection instructions, respondents can provide the requested data in the desired format, reporting burden (time and financial resources) is minimized, collection instructions are clearly understood, and the Department can properly assess the impact of collection requirements on respondents.

As discussed above, these proposed regulations would require plans providing disability benefits to meet additional requirements when complying with the Department's claims procedure regulation. Some of these requirements would require disclosures covered by the PRA. These requirements include disclosing information to ensure a full and fair review of a claim or appeal, and the content of notices of benefit determinations.

Currently, the Department is soliciting 60 days of public comments concerning these disclosures. The Department has submitted a copy of these proposed regulations to OMB in accordance with 44 U.S.C. 3507(d) for review of the information collections. The Department and OMB are particularly interested in comments that:

- Evaluate whether the collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;
- Evaluate the accuracy of the agency's estimate of the burden of the collection of information, including the validity of the methodology and assumptions used;
- Enhance the quality, utility, and clarity of the information to be collected; and
- Minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, for example, by permitting electronic submission of responses.

Comments should be sent to the Office of Information and Regulatory Affairs, Attention: Desk Officer for the Employee Benefits Security Administration either by fax to (202) 395-7285 or by email to oir_submission@omb.eop.gov. A copy of the ICR may be obtained by contacting the PRA addressee: G. Christopher Cosby, Office of Policy and Research, U.S. Department of Labor, Employee Benefits Security Administration, 200 Constitution Avenue, NW, Room N-5718, Washington, DC 20210. Telephone: (202) 693-8410; Fax: (202) 219-4745. These are not toll-free numbers. E-mail: ebsa.opr@dol.gov. ICRs submitted to OMB also are available at [reginfo.gov](http://www.reginfo.gov/public/do/PRAMain) (<http://www.reginfo.gov/public/do/PRAMain>).

ERISA-covered group health plans already are required to comply with the requirements of the Section 503 Regulation. The Section 503 Regulation requires, among other things, plans

to provide a claimant who is denied a claim with a written or electronic notice that contains the specific reasons for denial, a reference to the relevant plan provisions on which the denial is based, a description of any additional information necessary to perfect the claim, and a description of steps to be taken if the participant or beneficiary wishes to appeal the denial. The regulation also requires that any adverse decision upon review be in writing (including electronic means) and include specific reasons for the decision, as well as references to relevant plan provisions.

With the implementation of the ACA claims regulations, participants of disability plans receive fewer procedural protections than participants in group health plan participants, while they experience similar if not significantly more issues with the claims review process. These proposed regulations would reduce the inconsistent procedural rules applied to health and disability benefit plan claims and provide similar procedural protections to both groups of plan participants.

The burdens associated with this proposed regulatory requirements are summarized below.

Type of Review: Revised collection.

Agencies: Employee Benefits Security Administration, Department of Labor

Title: ERISA Claims Procedures

OMB Number: 1210-0053

Affected Public: Business or other for-profit; not-for-profit institutions.

Total Respondents: 5,961,000

Total Responses: 311,867,000

Frequency of Response: Occasionally.

Estimated Total Annual Burden Hours: 515,000

Estimated Total Annual Burden Cost: \$654,579,000

8. *Congressional Review Act*

These proposed regulations are subject to the Congressional Review Act provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801 et seq.) and, if finalized, would be transmitted to Congress and the Comptroller General for review. The proposed rule is not a “major rule” as that term is defined in 5 U.S.C 804, because it is not likely to result in an annual effect on the economy of \$100 million or more.

9. *Unfunded Mandates Reform Act*

Title II of the Unfunded Mandates Reform Act of 1995 (Public Law 104-4) requires each Federal agency to prepare a written statements assessing the effects of any Federal Mandate in a proposed or final agency rule that may result in annual expenditures of \$100 million (as adjusted for inflation) in any one year by State, local and tribal governments, in the aggregate, or the private sector. Such a mandate is deemed to be a “significant regulatory action.” These proposed regulations are not a “significant regulatory action.” Therefore the Department concludes that these proposed regulations would not impose an unfunded mandate on State, local and tribal governments, in the aggregate, or the private sector.

10. *Federalism Statement*

Executive Order 13132 outlines fundamental principles of federalism, and requires the adherence to specific criteria by Federal agencies in the process of their formulation and implementation of policies that have “substantial direct effects” on the States, the relationship between the national government and States, or on the distribution of power and responsibilities among the various levels of government. Federal agencies promulgating regulations that have federalism implications must consult with State and local officials and describe the extent of

their consultation and the nature of the concerns of State and local officials in the preamble to the final regulation.

In the Departments of Labor's view, these proposed regulations have federalism implications because they would have direct effects on the States, the relationship between the national government and the States, or on the distribution of power and responsibilities among various levels of government to the extent states have enacted laws affecting disability plan claims and appeals that contain similar requirements to the proposal. The Department believes these effects are limited, because although section 514 of ERISA supersedes State laws to the extent they relate to any covered employee benefit plan, it preserves State laws that regulate insurance, banking, or securities. In compliance with the requirement of Executive Order 13132 that agencies examine closely any policies that may have federalism implications or limit the policy making discretion of the States, the Department welcomes input from affected States, including the National Association of Insurance Commissioners and State insurance officials, regarding this assessment.

List of Subjects in 29 CFR Part 2560

Claims, Employee benefit plans, Pensions.

For the reasons stated in the preamble, the Department of Labor proposes to amend 29 CFR part 2560 as set forth below:

PART 2560—RULES AND REGULATIONS FOR ADMINISTRATION AND ENFORCEMENT

1. The authority citation for part 2560 is revised to read as follows:

Authority: 29 U.S.C. 1132, 1135, and Secretary of Labor’s Order 1–2011, 77 FR 1088 (Jan. 9, 2012). Section 2560.503-1 also issued under 29 U.S.C. 1133. Section 2560.502c-7 also issued under 29 U.S.C. 1132(c) (7). Section 2560.502c-4 also issued under 29 U.S.C. 1132(c)(4). Section 2560.502c-8 also issued under 29 U.S.C. 1132(c)(8).

2. Section 2560.503-1 is amended by:

- a. Adding paragraph (b)(7).
- b. Revising paragraph (g)(1)(v) introductory text.
- c. Adding paragraphs (g)(1)(vii) and (viii).
- d. Revising paragraphs (h)(4), (i)(3)(i), and (j)(5) introductory text.
- e. Adding paragraphs (j)(6) and (7).
- f. Revising paragraphs (l) and (m)(4).
- g. Adding paragraphs (m)(9) and (p).

The revisions and additions read as follows:

§ 2560.503–1 Claims procedure.

* * * * *

(b) ***

(7) In the case of a plan providing disability benefits, the plan must ensure that all claims and appeals for disability benefits are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with

respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support the denial of benefits.

* * * * *

(g) *** (1) ***

(v) In the case of an adverse benefit determination by a group health plan—

* * * * *

(vii) In the case of an adverse benefit determination with respect to disability benefits—

(A) 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;

(B) Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist; and

(C) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. Whether a document, record, or other information is relevant to a claim for benefits shall be determined by reference to paragraph (m)(8) of this section.

(viii) In the case of an adverse benefit determination with respect to disability benefits, the notification shall be provided in a culturally and linguistically appropriate manner (as described in paragraph (p) of this section).

* * * * *

(h) ***

(4) Plans providing disability benefits. The claims procedures of a plan providing disability benefits will not, with respect to claims for such benefits, be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless, in addition to complying with the requirements of paragraphs (h)(2)(ii) through (iv) and (h)(3)(i) through (v) of this section, the claims procedures—

(i) Allow a claimant to review the claim file and to present evidence and testimony as part of the disability benefit claims and appeals process;

(ii) Provide that, before the plan can issue an adverse benefit determination on review on a disability benefit claim, the plan administrator shall provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the plan (or at the direction of the plan) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided under paragraph (i) of this section to give the claimant a reasonable opportunity to respond prior to that date; and

(iii) Provide that, before the plan can issue an adverse benefit determination on review on a disability benefit claim based on a new or additional rationale, the plan administrator shall provide the claimant, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided under paragraph (i) of this section to give the claimant a reasonable opportunity to respond prior to that date.

* * * * *

(i) ***

(3) Disability claims. (i) Except as provided in paragraph (i)(3)(ii) of this section, claims involving disability benefits (whether the plan provides for one or two appeals) shall be governed by paragraph (i)(1)(i) of this section, except that a period of 45 days shall apply instead of 60 days for purposes of that paragraph.

* * * * *

(j) ***

(5) In the case of a group health plan—

(6) In the case of an adverse benefit decision with respect to disability benefits—

(i) 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; and

(ii) Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist.

(7) In the case of an adverse benefit determination on review with respect to a claim for disability benefits, the notification shall be provided in a culturally and linguistically appropriate manner (as described in paragraph (p) of this section).

* * * * *

(1) Failure to establish and follow reasonable claims procedures. (1) In general. Except as provided in paragraph (1)(2) of this section, in the case of the failure of a plan to establish or follow claims procedures consistent with the requirements of this section, a claimant shall be deemed to have exhausted the administrative remedies available under the plan and shall be entitled to pursue any available remedies under section 502(a) of the Act on the basis that the plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

(2) Plans providing disability benefits. (i) In the case of a claim for disability benefits, if the plan fails to strictly adhere to all the requirements of this section with respect to a claim, the claimant is deemed to have exhausted the administrative remedies available under the plan, except as provided in paragraph (1)(2)(ii) of this section. Accordingly, the claimant is entitled to pursue any available remedies under section 502(a) of ERISA on the basis that the plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim. If a claimant chooses to pursue remedies under section 502(a) of ERISA under such circumstances, the claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary.

(ii) Notwithstanding paragraph (1)(2)(i) of this section, the administrative remedies available under a plan with respect to claims for disability benefits will not be deemed exhausted based on *de minimis* violations that do not cause, and are not likely to cause, prejudice or harm to the claimant so long as the plan demonstrates that the violation was for good cause or due to matters beyond the control of the plan and that the violation occurred in the context of an ongoing, good faith exchange of information between the plan and the claimant. This exception is not available if the violation is part of a pattern or practice of violations by the plan. The

claimant may request a written explanation of the violation from the plan, and the plan must provide such explanation within 10 days, including a specific 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. If a court rejects the claimant's request for immediate review under paragraph (1)(2)(i) of this section on the basis that the plan met the standards for the exception under this paragraph (1)(2)(ii), the claim shall be considered as re-filed on appeal upon the plan's receipt of the decision of the court. Within a reasonable time after the receipt of the decision, the plan shall provide the claimant with notice of the resubmission.

* * * * *

(m) ***

(4) The term "adverse benefit determination" means:

(i) Any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate; and

(ii) In the case of a plan providing disability benefits, the term "adverse benefit determination" also means any rescission of disability coverage with respect to a participant or beneficiary (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time). For this purpose, the term "rescission" means a cancellation or

discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

* * * * *

(9) The term "claim file" means the file or other compilation of relevant information, as described in paragraph (m)(8) of this section, to be considered in the full and fair review of a disability benefit claim.

* * * * *

(p) Standards for culturally and linguistically appropriate notices. A plan is considered to provide relevant notices in a “culturally and linguistically appropriate manner” if the plan meets all the requirements of paragraph (p)(1) of this section with respect to the applicable non-English languages described in paragraph (p)(2) of this section.

(1) Requirements. (i) The plan must provide oral language services (such as a telephone customer assistance hotline) that include answering questions in any applicable non-English language and providing assistance with filing claims and appeals in any applicable non-English language;

(ii) The plan must provide, upon request, a notice in any applicable non-English language; and

(iii) The plan must include in the English versions of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the plan.

(2) Applicable non-English language. With respect to an address in any United States county to which a notice is sent, a non-English language is an applicable non-English language if

ten percent or more of the population residing in the county is literate only in the same non-English language, as determined in guidance published by the Secretary.

Signed at Washington, DC, this 6th_day of November, 2015.

Phyllis C. Borzi,
Assistant Secretary, Employee Benefits Security Administration,
U.S. Department of Labor

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