DEPARTMENT OF LABOR

Employee Benefits Security Administration

29 CFR Part 2560

RIN 1210-AB39

Claims Procedure for Plans Providing Disability Benefits; Extension of Applicability Date

AGENCY: Employee Benefits Security Administration, Department of Labor.

ACTION: Proposed rule.

SUMMARY: The Department of Labor proposes to delay for ninety (90) days – through April 1, 2018 – the applicability of the Final Rule amending the claims procedure requirements applicable to ERISA-covered employee benefit plans that provide disability benefits. The Final Rule was published in the Federal Register on December 19, 2016, and became effective on January 18, 2017. The Final Rule currently is scheduled to apply to claims for disability benefits under ERISA-covered employee benefit plans that are filed on or after January 1, 2018. Following publication of the Final Rule, various stakeholders and members of Congress asserted that it will drive up disability benefit plan costs, cause an increase in litigation, and in so doing impair workers' access to disability insurance benefits. Pursuant to Executive Order 13777, the Department of Labor has concluded that it is appropriate to give the public an additional opportunity to submit comments and data concerning potential impacts of the Final Rule. The Department of Labor will carefully consider the submitted comments and data as part of its effort to examine regulatory alternatives that meet its objectives of ensuring the full and fair review of disability benefit claims while not imposing unnecessary costs and

adverse consequences. The Department of Labor accordingly seeks public comment on a proposed 90-day delay of the applicability of the Final Rule in order to solicit additional public input and examine regulatory alternatives. If this proposal is finalized, the amendments made on December 19, 2016, would become applicable to claims for disability benefits that are filed after April 1, 2018, rather than January 1, 2018.

DATES: Comments on the proposal to extend the applicability date for 90 days must be submitted to the Department on or before [INSERT DATE 15 DAYS FROM DATE OF PUBLICATION IN THE FEDERAL REGISTER]. Comments providing data and otherwise germane to the examination of the merits of rescinding, modifying, or retaining the rule must be submitted to the Department on or before [INSERT DATE THAT IS 60 DAYS FROM THE DATE OF PUBLICATION IN THE FEDERAL REGISTER].

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.

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 for Plans Providing Disability Benefits Examination.

Instructions: All submissions received must include the agency name and RIN for this rulemaking. Persons submitting comments electronically are encouraged to submit only by one electronic method and not to submit paper copies. 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. Comments are public records and are posted on the Internet as received, and can be retrieved by most internet search engines.

SUPPLEMENTARY INFORMATION: Section 503 of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), requires that every employee benefit plan shall establish and maintain reasonable procedures governing the filing of benefit claims, notification of benefit determinations, and appeal of adverse benefit determinations. In accordance with its authority under ERISA section 503, and its general regulatory authority under ERISA section 505, the Department of Labor ("Department") long ago established regulations setting forth minimum requirements for employee benefit plan procedures pertaining to claims for benefits by participants and beneficiaries. 29 CFR § 2560.503-1.

On December 19, 2016, the Department published a final regulation ("Final Rule") amending the existing claims procedure regulation; the Final Rule revised the

claims procedure rules for ERISA-covered employee benefit plans that provide disability benefits. The Final Rule was made effective January 18, 2017, but the Department delayed its applicability until January 1, 2018, in order to provide adequate time for disability benefit plans and their affected service providers to adjust to it, as well as for consumers and others to understand the changes made.

The Final Rule requires that plans, plan fiduciaries, and insurance providers comply with certain requirements when dealing with disability benefit claimants. In summary, the Final Rule includes the following requirements for the processing of claims and appeals for disability benefits:

- **Disclosure Requirements.** Benefit denial notices must contain a more complete discussion of why the plan denied a claim and the standards it used in making the decision. For example, notices must include a discussion of the basis for disagreeing with a disability determination made by the Social Security Administration ("SSA") if presented by the claimant in support of his or her claim.

- **Claim File and Internal Protocols.** Benefit denial notices must include a statement that the claimant is entitled to receive, upon request, the entire claim file and other relevant documents. Currently, this statement is required only in notices denying benefits on appeal. Benefit denial notices also must include the internal rules, guidelines, protocols, standards, or other similar criteria of the plan that were used in denying a claim, or a statement that none were used. Currently, denial notices are not required to include these internal rules, guidelines, protocols, or standards; instead denial notices may include a statement that such rules, guidelines, protocols, or standards were used in denying the claim and that a copy will be provided to the claimant upon request.

- **Review and Respond to New Information.** Plans may not deny benefits on appeal based on new or additional evidence or rationales that were not included when the benefit was denied at the claims stage, unless the claimant is given notice and a fair opportunity to respond.

- **Conflicts of Interest.** Plans must ensure that 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. For example, a claims adjudicator or medical or vocational expert could not be hired, promoted, terminated, or compensated based on the likelihood of the person denying benefit claims.

- **Deemed Exhaustion.** If a plan does 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 conditions are met. If the claimant is deemed to have exhausted the administrative remedies available under the plan, the claim or appeal is deemed denied on review without the exercise of discretion by a fiduciary and the claimant may immediately pursue his or her claim in court. A plan also must treat a claim as re-filed on appeal upon the plan's receipt of a court's decision rejecting the claimant's request for review.

- **Coverage Rescissions.** Rescissions of coverage, including retroactive terminations due to alleged misrepresentation of fact (*e.g.*, errors in the application for coverage) must be treated as adverse benefit determinations, thereby triggering the plan's appeals procedures. Rescissions for non-payment of premiums are not covered by this provision.

- **Communication Requirements in Non-English Languages.** Benefit denial notices have to be provided in a non-English language in certain situations, using essentially the standard applicable to group health benefit notices under the Affordable Care Act ("ACA"). Specifically, if a disability claimant's address is in a county where 10 percent or more of the population is literate only in the same non-English language, benefit denial notices must include a prominent statement in the relevant non-English language about the availability of language services. In such cases, plans also would be required to provide oral language services in the relevant non-English language and provide written notices in the non-English language upon request.

When it adopted the Final Rule, the Department published a regulatory impact analysis ("RIA") to support its conclusion that changes to the existing rules were necessary to ensure that disability claimants receive a full and fair review of their claims. The Department found at that time that the Final Rule would change the claims review process for ERISA-covered disability plans by expanding due process rights. The analysis concluded that: (1) the Final Rule would help alleviate the hardship to many individuals when they are unable to work after becoming disabled and their claims are unfairly denied; and (2) greater 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, would 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.

On the cost side, the RIA concluded that the amendments would have modest costs, since many of the amendments clarified provisions of the claims procedure

regulation or required the provision of information to claimants that adjudicators should already possess. Although the Department requested data when it first proposed amendments to the claims procedure regulation in April 2015 ("2015 NPRM"), the comment letters received generally did not contain alternative cost and benefits estimates or data that the Department could use to estimate costs and benefits for the Final Rule. However, the Department quantified the costs associated with two specific provisions in the Final Rule for which it had sufficient data: the requirements to provide (1) additional information to claimants in the appeals process; and (2) information in a non-English language. The RIA acknowledged that the Department did not have sufficient data to quantify the benefits associated with the Final Rule.

After the Department published the Final Rule, certain stakeholders asserted in writing that the Final Rule will drive up disability benefit plan costs, cause an increase in litigation, and thus impair workers' access to disability insurance protections.[1] In support of these assertions, the stakeholders say that the right to review and respond to new information or rationales unnecessarily "complicates the processing of disability benefits by imposing new steps and evidentiary burdens in the adjudication of claims," and that some of the new disclosure requirements "forc[e] plans to consider disability standards

[1] Some of the stakeholders also asserted a comment that was previously provided with respect to the 2015 NPRM, specifically that the Department exceeded its authority and acted contrary to Congressional intent by applying certain ACA protections to disability benefit claims, arguing that if Congress had wanted these protections to apply to disability benefit claims, it would have expressly extended the claims and appeals rules in section 2719 of the Public Health Service Act to plans that provide disability benefits. The Department did not take the position that the ACA compelled the changes in the Final Rule. Rather, because disability claims commonly involve medical considerations, the Department was of the view that disability benefit claimants should receive procedural protections similar to those that apply to group health plans, and thus it made sense to model the Final Rule on the procedural protections and consumer safeguards that Congress established for group health care claimants under the ACA.

and definitions different from those in the plan."[2] In addition, the stakeholders say that the new deemed exhaustion provision "explicitly tilts the balance in court cases against plans and insurers" and "creates perverse incentives for plaintiff's attorneys to side-step established procedures and clog the courts for resolution of benefit claims."[3] The stakeholders argue that these provisions (and others) collectively "will delay any final decision for the claimant and will significantly increase the administrative burdens on employers and disability insurance carriers, hurting the very employee the rule was purporting to help."[4] Moreover, according to the stakeholders, these new provisions (and others) are unnecessary in any event because "there are already existing robust consumer protections applicable and available to disability claimants that have worked for well over a decade."[5] Members of Congress also presented these same or similar concerns in writing to the Secretary of Labor.[6]

A confidential survey of carriers covering approximately 18 million participants in group long term disability plans (which reflects approximately 45% of the group long-term disability insurance market), conducted by the stakeholders estimated that the Final Rule would cause average premium increases of 5 – 8 % in 2018 (when the Final Rule is

[2] Letter from Governor Dirk Kempthorne, President & Chief Executive Officer, American Council of Life Insurers, to The Honorable Alexander Acosta, Secretary, U.S. Department of Labor, "*Department of Labor Disability Claims Regulation*," (July 17, 2017) (on file with the Employee Benefits Security Administration, U.S. Department of Labor).

[3] Letter from American Benefits Council, American Council of Life Insurers, America's Health Insurance Plans, Cigna, The ERISA Industry Committee, Financial Services Roundtable, Sun Life Financial, Unum Group, Inc., to Gary Cohn, Director, National Economic Council, The White House, Andrew P. Bremberg, Director, Domestic Policy Council, The White House, Edward C. Hugler, Acting Secretary, U.S. Department of Labor, "*Department of Labor Disability Claims Regulation*," (Mar. 14, 2017) (on file with the Employee Benefits Security Administration, U.S. Department of Labor).

[4] Letter from Governor Dirk Kempthorne, *supra*, note 2.

[5] *Id*.

[6] Letter from David P. Roe, M.D., Member of Congress (and 27 other Members of Congress), to R. Alexander Acosta, Secretary, U.S. Department of Labor, "*Immediate Action Needed on Disability Claims Regulation*," (July 28, 2017) (on file with the Employee Benefits Security Administration, U.S. Department of Labor).

scheduled to take effect) for several survey participants.[7] The stakeholders argue that the demand for disability insurance is highly sensitive to price changes, such that even minor price increases can result in take-up rate reductions. For example, they reported that when the State of Vermont mandated mental health parity several years ago, there was an approximately 20% increase in premiums, which resulted in a 20% decrease of covered employees.[8] Thus, they conclude that the cost increases caused by the Final Rule will result in employers reducing and/or eliminating disability income benefits, and that some individuals may elect to drop or forego coverage, with the result being that fewer people will have adequate income protection in the event of disability. The stakeholders further assert that loss of access not only may be adverse to individual workers and their families, but also potentially adverse to federal and state public assistance programs more generally.[9]

The stakeholders acknowledge that the Final Rule's RIA addressed the limited data sources that were publicly available at that time, and that the Department's ability to fully quantify and evaluate costs and benefits was accordingly constrained. But the stakeholders say that such data could be developed by the industry and provided to the Department, and have promised to work with the Department to obtain this data. They explain that collecting the relevant data is a complex process that will take time and

[7] Email from Michael Kreps, Principal, Groom Law Group, to John J. Canary and Jeffrey J. Turner, Office of Regulations and Interpretations, Employee Benefits Security Administration (July 13, 2017) (on file with the Employee Benefits Security Administration, U.S. Department of Labor).
[8] *Id*.
[9] *See*, *e.g.*, Letter from Matthew Eyles, Executive Vice President, Policy and Regulatory Affairs, America's Health Insurance Plans, to The Honorable R. Alexander Acosta, Secretary of Labor, U.S. Department of Labor (May 10, 2017) (on file with the Employee Benefits Security Administration, U.S. Department of Labor). *See also* Letter from David P. Roe, M.D., Member of Congress (and 27 other Members of Congress), to R. Alexander Acosta, Secretary, U.S. Department of Labor, "*Immediate Action Needed on Disability Claims Regulation*," (July 28, 2017) (on file with the Employee Benefits Security Administration, U.S. Department of Labor).

involve an expenditure of resources. For example, because each carrier's data is proprietary and contains sensitive business information, an independent third party must collect it in a manner that protects this information. This may include, among other things, negotiating specific non-disclosure, security, and data retention agreements. They further observe that such a process must also be carefully designed to ensure that there are no violations of relevant federal or state laws, such as antitrust laws. The stakeholders also assert that each carrier's existing information technology systems may collect and report data in different ways, so, to be usable, the data must be aggregated into standardized data sets, anonymized to ensure that no data point can be attributed to a single carrier, and reviewed and analyzed to ensure accuracy and reliability (as required for a regulatory impact analysis). The stakeholders made a commitment to provide this data and asked the Department to delay the Final Rule's applicability date.

On February 24, 2017, after the Final Rule amending the disability claims procedure was published and became effective, the President issued Executive Order 13777 ("EO 13777"), entitled Enforcing the Regulatory Reform Agenda.[10] EO 13777 is intended to reduce the regulatory burdens agencies place on the American people, and directs federal agencies to undertake specified activities to accomplish that objective. As a first step, EO 13777 requires the designation of a Regulatory Reform Officer and the establishment of a Regulatory Reform Task Force within each federal agency covered by the Order. The Task Forces were directed to evaluate existing regulations and make recommendations regarding those that can be repealed, replaced, or modified to make them less burdensome. EO 13777 also requires that Task Forces seek input from entities

[10] 82 FR 12285 (March 1, 2017).

significantly affected by regulations, including state, local and tribal governments, small businesses, consumers, non-governmental organizations, and trade associations.

In light of the foregoing, the Department has concluded that it is appropriate to seek additional public input regarding the regulatory impact analysis in the Final Rule. If additional reliable data and information is submitted, the Department will be able to consider whether it supports regulatory alternatives other than those adopted in the Final Rule. The Department is unable to complete a notice and comment and reexamination process by January 1, 2018, particularly given the complex data collection and sanitation process required here, as described by the stakeholders. Extending the applicability date past January 1, 2018, would allow the Department to complete this public solicitation process and examine regulatory alternatives. The Department consequently seeks public input on a proposed 90-day delay.[11] For reasons discussed below, the Department believes 90 days is a reasonable period during which to review public input and take an appropriate course of action.

As indicated above, a primary concern of the stakeholders is that the Final Rule will unnecessarily increase the cost of coverage and discourage the uptake and utilization of disability coverage. While a number of the commenters on the 2015 NPRM forecasted increased regulatory and compliance costs as a whole, few, if any, of them offered

[11] The Department notes that several provisions in the Final Rule essentially conform the express text of certain parts of the Final Rule to various federal court decisions on full and fair review requirements in the 2000 Final Rule. *E.g., Saffon v. Wells Fargo & Co. Long Term Disability Plan*, 522 F.3d 863, 871-872 (9th Cir. 2008) (finding that a full and fair review requires a plan administrator to disclose the reasons for denial in the administrative process); 75 FR at 43333 n.7. The proposed delay of the applicability date in this document does not modify or otherwise delay the application of any such controlling judicial precedents.

itemized cost estimates on a provision-by-provision basis.[12] The Department recognizes that access to disability benefits depends in part on affordability, which is affected by regulatory burdens. Accordingly (as opposed to generalized predictions of cost increases or aggregate cost estimates of the Final Rule in its entirety), the Department solicits costs estimates on each of the provisions contained in that rule. Itemized cost estimates of this type would enhance the Department's ability to assess costs and benefits of regulatory alternatives and to select approaches that maximize net benefits.

The Department also seeks data on the price elasticity of demand for disability insurance coverage. Many stakeholders, for example, discuss price sensitivity in this market and predict possibly significant reductions in access to coverage unless the Final Rule is revised or repealed (*i.e.*, that the price elasticity of demand in this market is relatively elastic). Evidence of this elasticity would be very helpful to the Department. For example, a number of states (some very recently) have banned discretionary clauses in insurance policies, which may have resulted in increased administrative costs. In those cases, is there data showing reduced demand (in terms of dropped coverage or reduced uptake) following the implementation of the bans? Another example is the Final Rule's requirement to discuss the basis for disagreeing with a disability determination made by the SSA. Is there data showing a detrimental impact on coverage in jurisdictions where

[12] *See, e.g.*, Comment Letter # 115 (American Benefits Council) (asserting generally that the 2015 NPRM "is likely to impose a host of additional costs on plans – none of which appear to have been considered by the Department as part of its economic analysis."); *see also* Comment Letter # 114 (American Council of Life Insurers) (asserting that it "does not believe that the Department has properly quantified or qualified the benefits associated with the proposed regulations or provided a sufficient cost analysis associated with the proposed regulatory requirements.").

courts[13] have endorsed such an explanation? Another possible example is the changes to the claims procedure requirements made in 2000.[14] Is there data showing a detrimental impact on coverage after those revisions were made? This is not an exhaustive list of potentially relevant situations or questions; instead, it is intended to provide insight into issues the Department intends to consider and as to which comments will be helpful.

The Department also seeks comments on any matter germane to this examination, including the merits of rescinding, modifying, or retaining the Final Rule. Upon completion of this public solicitation process and review, the Department may decide to allow all or part of the Final Rule to take effect as written, propose a further extension, withdraw the Final Rule, or propose amendments to the Final Rule. The Department requests comments on each of these possible outcomes.

Comments on whether to extend the applicability date for 90 days must be submitted to the Department within 15 days. If the 90-day period is insufficient, please specify a sufficient period of time and explain why longer than 90 days is needed. Comments providing data or otherwise germane to the examination of the merits of rescinding, modifying, or retaining the rule must be submitted to the Department within 60 days. If 60 days is not enough time to provide input on the broader examination, including responding to the various data requests throughout this document, commenters

[13] *See, e.g.*, *Montour v. Hartford Life and Accident Ins. Co.*, 588 F.3d 623, 637 (9th Cir. 2009) ("[F]ailure 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."); *Brown v. Hartford Life Ins. Co.*, 301 F. App'x 772, 776 (10th Cir. 2008) (insurer's discussion was "conclusory" and "provided no specific discussion of how the rationale for the SSA's decision, or the evidence the SSA considered, differed from its own policy criteria or the medical documentation it considered").

[14] In November of 2000, the Department published a final rule substantially reforming the standards governing the timeframes and disclosure requirements for ERISA benefit claims and appeals, including disability benefits. 65 FR 70246 (Nov. 21, 2000).

are encouraged to notify the Department within the 15-day period, and to explain why 60 days is not enough time and specify how much time is needed. This will give the Department an opportunity to consider whether to extend the 60-day comment period in conjunction with a decision on whether and how long to delay the applicability date.

Regulatory Impact Analysis

The Department proposes to delay the applicability date of the Final Rule for 90 days – through April 1, 2018. During the delay, the Department will review the Final Rule to determine whether it is unnecessary, ineffective, or imposes costs that exceed benefits in conformance with EO 13777. As part of this process, the Department also will review data submitted on the issues raised on the RIA in the Final Rule to determine whether such new information and data support changes to the Final Rule.

The delay is necessary to avoid the applicability date of the Final Rule occurring before the Department completes its review, which would necessarily require those regulated by the Final Rule to prepare for and begin complying on January 1, 2018 while the Department is still reviewing the rule. That would unnecessarily and unwisely disrupt the disability insurance market and produce frictional costs that are not offset by commensurate benefits. The tradeoff is that the changes in the Final Rule will be delayed.

1. Executive Order 12866 Statement

This proposed extension of the applicability date of the Final Rule is a significant regulatory action within the meaning of section 3(f)(4) of Executive Order 12866, because it raises novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in the Executive Order. Therefore, the Department

has considered the costs and benefits of the proposed extension, and the Office of Management and Budget ("OMB") has reviewed and approved the proposed applicability date extension.

The Department's regulatory impact analysis of the Final Rule estimated that benefits derived by workers seeking disability benefits justify compliance costs.[15] The 90-day delay of the applicability date would delay these estimated costs and benefits by 90 days.

Data limitations prevented the Department from quantifying benefits the Final Rule would provide to workers and their family members participating in ERISA-covered disability insurance plans. The RIA for the Final Rule includes a qualitative analysis of the benefits. The Department estimated at that time that as a result of the rule:

- Some participants would receive payment for benefits they were entitled to that were improperly denied by the plan;
- There would be 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;
- Fairness and accuracy would increase in the claims adjudication process.

The Department estimated that the requirements of the Final Rule would have modest costs. The Department quantified the costs associated with two provisions of the Final Rule for which it had sufficient data: the requirements to provide: (1) providing additional information to claimants in the appeals process ($14.5 million annually); and (2) providing information in a non-English language ($1.3 million annually).

[15] 81 FR 92316, 92339 (Dec. 19, 2016).

Stakeholders have raised concerns that the Department underestimated the costs of the Final Rule and maintain that if the Department had properly estimated costs, it would have found that the costs exceed the Final Rule's benefits. Specifically, stakeholders assert that: (1) requiring benefit denial notices include a discussion of the basis for disagreeing with a disability determination made by the SSA will increase costs because SSA's definitions, policies, and procedures may be different from those of private disability plans; (2) providing that the claimant is deemed to have exhausted the administrative remedies available under the plan if plans do not adhere to all claims processing rules, unless the violation was the result of a minor error and other specified conditions are met, will result in increased litigation and administrative costs; and (3) prohibiting plans from denying benefits on appeal based on new or additional evidence or rationales that were not included when the benefit was denied at the claims stage, unless the claimant is provided notice and an opportunity to respond to the new or additional information or rationales, will lead to protracted exchanges between plans and claimants that will cause delays and lead to higher costs. Stakeholders also argue that participants in disability plans are very sensitive to price increases and predict that the cost increases associated with the Final Rule will cause some individuals to elect to drop or forego coverage, meaning that fewer people will have adequate income protection in the event of disability.

During the proposed 90-day applicability date delay, the Department intends to assess the impacts of the Final Rule. In order for the assessment to be as robust as possible, the Department is hereby requesting data that would help it quantify the payments for plan benefits that plan participants would receive and any cost increases or

reductions in access to coverage that could result if the delayed provisions of the Final Rule take effect. Specifically, the Department requests data that it could use to assess: (1) the number of disability claims that are filed and denial rates for such claims, including rates separately for claimants who were previously approved under the Social Security Disability Insurance Program (SSDI) and statistics on reasons for denial; (2) how often plans rely on new or additional evidence or rationales during the claims review process and the volume of the material that comprise such additional evidence or rationales; (3) the price elasticity of demand for disability insurance coverage; (4) pricing or premiums for group and individual level policies and factors that affect pricing; (5) loss ratios and the breakdown of expenses (claims, sales, claims processing, etc.); (6) aggregate, average, and median benefits paid and ages of claimants; (7) the projected litigation costs associated with the new procedural requirements for disability claims provided in the Final Rule; (8) the number of new claims that will be granted that, but for the provisions in the Final Rule, would have been denied, and the value of those benefits; (9) the systems and technology that plans and insurers use to process disability claims and cost estimates updating such systems to comply with the Final Rule; (10) statistics on steps, timing of steps, and disposition of claims from initial filing to final disposition, including claims filed but never perfected or decided, up to and including claims denied though appeal and litigated; and (11) information regarding the costs for non-English services and the estimated population of claimants that might be expected to use such services. The Department understands that such data is not publicly available and is willing to work with stakeholders to ensure that any trade secrets and proprietary business information are protected from public disclosure and that the data collection

process is designed to ensure that no violations of antitrust or other federal or state laws occur.[16]

It also would be helpful for the Department to receive data regarding the impact of the 2000 final claims and appeals regulation (2000 Final Rule). Commenters at the time stated that it would lead to cost increases and decreases in consumer access. The Department is interested in receiving data that shows: (1) cost increases that resulted from compliance with the 2000 Final Rule (or lack thereof) and whether such costs were passed on to consumers; and (2) whether employers stopped offering disability insurance benefits and/or employee take-up rates decreased. The Department also requests data that demonstrates how the Department's 2000 Final Rule impacted the cost of disability claims litigation.

While the Department welcomes the submission of all relevant data, to ensure its usability, the providers of such data are encouraged to discuss its source(s), manner of collection, and any methodology used to analyze it and derive conclusions from it. The Department requests that commenters fully disclose any bias(es) associated with the data and provide honest evaluations of its strengths and weaknesses. This will help ensure that the Department reaches an optimal outcome and that full transparency is provided to the public.

2. Paperwork Reduction Act

---

[16] The Department is aware of a number of relevant annual and semiannual industry surveys, such as the U.S. Group Disability Market Survey. Where applicable, commenters are encouraged to submit to the Department the data underlying these surveys. *See, e.g.*, the American Council of Life Insurers' Written Statement for the Record entitled *Do Private Long-Term Disability Policies Provide the Protection They Promise? Before the S. Comm. on Finance*, 111th Cong. 113 & n.3 (2010), in which the ACLI discusses aggregate data on approvals and elimination periods.

The Paperwork Reduction Act ("PRA") prohibits federal agencies from conducting or sponsoring a collection of information from the public without first obtaining approval from OMB. *See* 44 U.S.C. § 3507. Additionally, members of the public are not required to respond to a collection of information, nor be subject to a penalty for failing to respond, unless such collection displays a valid OMB control number. *See* 44 U.S.C. § 3512.

OMB approved information collections contained in the Final Rule under OMB Control Number 1210-0053. The Department is not modifying the substance of the Information Collection Requests at this time; therefore, no action under the PRA is required. The information collections will become applicable at the same time the rule becomes applicable. The information collection requirements contained in the Final Rule are discussed below.

This proposal would delay the applicability date of the Department's amendments to the disability claims procedure rule for 90 days, through April 1, 2018. The Final Rule revised the rules applicable to ERISA-covered plans providing disability benefits. Some of these amendments revise disclosure requirements under the claims procedure rule that are information collections covered by the PRA. For example, benefit denial notices must contain a full discussion of why the plan denied the claim, and to the extent the plan did not follow or agree with the views presented by the claimant to the plan or health care professional treating the claimant or vocational professionals who evaluated the claimant, or a disability determination regarding the claimant presented by the claimant to the plan made by the SSA, the discussion must include an explanation of the basis for disagreeing with the views or disability determination. The notices also must include either: (1) the

specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making the adverse determination or, alternatively, (2) a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist. Plan administrators also must provide (1) claimants with any new or additional evidence considered free of charge, and (2) notices of adverse benefit determination potentially in an non-English language.

The burdens associated with the disability claims procedure revisions are summarized below and discussed in detail in the regulatory impact analysis contained in the preamble to the Final Rule (81 FR 92317, 92340 (Dec. 19, 2016)). It should be noted that this proposal only affects the requirements applicable to disability benefit claims, which are a small subset of the total burden associated with the ERISA claims procedure information collection.

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: 5,808,000. Total Responses: 311,790,000.

Frequency of Response: Occasionally.

Estimated Total Annual Burden Hours: 516,000.

Estimated Total Annual Burden Cost: $814,450,000.

3. Regulatory Flexibility Act

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 rule is not likely to have a significant economic impact on a substantial number of small entities, section 604 of the RFA requires the agency to present an initial regulatory flexibility analysis (IRFA) of the proposed rule describing the rule's impact on small entities and explaining how the agency made its decisions with respect to the application of the rule to small entities. Pursuant to section 605(b) of the RFA, the Department certified that the Final Rule did not have a significant economic impact on a substantial number of small entities and provided an analysis of the rationale for that certification. Similarly, the Department hereby certifies that the proposed rule will not have a significant economic impact on a substantial number of small entities because it merely delays the applicability date of the Final Rule.

4. Congressional Review Act

The proposed rule is subject to the Congressional Review Act (CRA) provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801 *et seq*.) and, if finalized, will be transmitted to Congress and the Comptroller General for review.

5. Unfunded Mandates Reform Act

Title II of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4) requires each federal agency to prepare a written statement assessing the effects of any federal

mandate in a proposed or final agency rule that may result in an expenditure of $100 million or more (adjusted annually for inflation with the base year 1995) in any one year by State, local, and tribal governments, in the aggregate, or by the private sector. For purposes of the Unfunded Mandates Reform Act, as well as Executive Order 12875, this proposal does not include any federal mandate that we expect would result in such expenditures by state, local, or tribal governments, or the private sector. The Department also does not expect that the proposed rule will have any material economic impacts on State, local or tribal governments, or on health, safety, or the natural environment.

6. 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 Rule.

This proposed rule does not have federalism implications because it merely delays the applicability date of the rule. Therefore, the proposed rule has no substantial direct effect on the States, the relationship between the national government and the States, or the distribution of power and responsibilities among the various levels of government. 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 States regarding this assessment.

7. Executive Order 13771: Reducing Regulation and Controlling Regulatory Costs

Executive Order 13771, titled Reducing Regulation and Controlling Regulatory Costs, was issued on January 30, 2017. Section 2(a) of EO 13771 requires an agency, unless prohibited by law, to identify at least two existing regulations to be repealed when the agency publicly proposes for notice and comment, or otherwise promulgates, a new regulation. In furtherance of this requirement, section 2(c) of EO 13771 requires that the new incremental costs associated with new regulations shall, to the extent permitted by law, be offset by the elimination of existing costs associated with at least two prior regulations. This proposed rule is expected to be an EO 13771 deregulatory action.

List of Subjects in 29 CFR Part 2560

Claims, Employee benefit plans.

For the reasons stated above, the Department proposes to amend 29 CFR part 2560 as follows:

PART 2560--RULES AND REGULATIONS FOR ADMINISTRATION AND ENFORCEMENT

1. The authority citation for part 2560 continues 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).

§ 2560.503–1 [Amended]

2. Section 2560.503-1 is amended by removing "on or after January 1, 2018" and adding in its place "after April 1, 2018" in paragraph (p)(3) and by removing the date "December 31, 2017" and adding in its place "April 1, 2018" in paragraph (p)(4).

Signed at Washington, DC, this 6th day of October, 2017.

_____

Timothy D. Hauser,

Deputy Assistant Secretary for Program Operations, Employee Benefits Security Administration, Department of Labor.

BILLING CODE 4510-29-P

[FR Doc. 2017-22082 Filed: 10/10/2017 8:45 am; Publication Date: 10/12/2017]