**From:** Susan Horner [mailto:SusanHorner@erisa-law.com]
**Sent:** Tuesday, October 24, 2017 8:03 PM
**To:** EBSA, E-ORI - EBSA
**Subject:** My Objection to the proposed 90-day delay in the effective date of the Regulations. RIN 1210-AB39

Dear Mr. Hauser,

I write in intense opposition to the proposed 90-day delay of the coming effective date of the DOL's new Disability Regulations. I am a partner of MILLER MONSON PESHEL POLACEK & HOSHAW in San Diego, California. I have represented employee plan participants and their beneficiaries nearly exclusively for over 25 years, primarily in welfare benefits issues of disability, life and accident, and, on rare occasion, pension. My practice includes all states of ERISA claims issues: at the claim level, appeals of adverse 'administrative' decisions, litigation in the district court and at the court of appeals. I have a medical background from my years in the medical field as a cardiac special procedures technologist prior to my legal career. That background has been indispensable in parsing through the opacity and unhelpful innuendo all too often encountered as the underlying basis for adverse decisions issued by insurers ---so much so that it appears to be a purposefully practiced communication style intended to bewilder or baffle claimants, and perplex their treating providers.

I have personally witnessed the proliferation of claim denials forcing claimants to litigate their claims in court, all the while left with no life insurance benefits in the loss of their loved one, and/or no disability benefits while still unable to work. I have witnessed the non-neutrality, non-objective nature of claims reviews in numerous fields —vocational/rehabilitation, medical, behavioral, psychologic/psychiatric, etc.— and the claims manager(s) themselves who each take an outright adversarial and sometimes hostile approach to the claim, particularly by the underwriting/insuring insurance companies. After issuance of the then-new regulations in 2000, effective-January 1, 2001, the DOL attempted to effectuate a more level playing field for disability claim gamesmanship by insurer 'administrators' so as to hopefully ensure greater protection of employee participants and beneficiaries. However, the claims administrators quickly learned how to manipulate and distort the spirit and meaning of those regulations in their self-interest, going to the highest degree in quoting policy terms ---sometimes just quoting anything including irrelevant provisions under one claim subsection, while simultaneously failing to connect the dots between the actual evidence in the record as a whole regarding the claimant's injury or

illness and actual basis for his or her disability. Refusing to communicate the latter in a plain, meaningful manner goes against the very population which ERISA's central underlying purpose of protection is for: employee protection. *Schikore v. BankAmerica Supplemental SI (MEJ) Retirement Plan*, 269 F.3d 956, 962-63 (9th Cir. 2001), citing 29 U.S.C.S. § 1001(b).

The economic incentives for insurers to deny valid claims from the start (or terminate within a short time), and release all reserves previously held to pay the claim into their general operating funds for investment ---achieving high returns on that equity--- makes their practice understandable from the standpoint of protecting their shareholders, even if after 2 to 5 years later they have to pay out the benefits that should have been paid to begin with. It also readily explains the explosion of such claims that have increasingly clogged the courts and proliferate such innumerable new case opinions that they are quickly becoming impossible to keep up with. The courts and the Department of Labor through its study of cases in the last ***16 years*** since the 2000 regulations took effect have recognized that this poor state of affairs is indeed contrary to the purposes of ERISA, and contrary to the most minimal basic requirements of each of the regulations. The DOL's decision to take aim at the 2000 regulations affecting plan administration of disability claims and focus enhanced attention on the protections for disability plan participants and beneficiaries was (and is) *long overdue.* It should not be further delayed.

These claims are typically 'adjudicated' by insurance carriers, whose business it is and has for well over a century to conduct thorough investigations of relevant and readily available information and to articulate and explain their decisions based on the evidence as a whole. The changes provided by the new regulations reinforce and enhance what the 2000 regulations attempted to accomplish *but for* the concerted efforts of the administrators' to circumvent. It is far past time to correct the commonplace occurrence of tricky, cryptic, opaque decisions that lack clarity and specificity, lack helpfulness or real meaning to the lay employee who has no expertise in the area but needs to understand the adverse decision in order to adequately appeal such decision. Yes, many of the adverse decision letters resort to unhelpful conclusory boilerplate —boilerplate which is seen parroted in many if not most adverse decisions and could apply to any number of conditions. Insurers resort to vague inferences instead of stating in clear language what they mean and what is missing (often because they never gave notice in advance that something specific was needed, and never requested it to

begin with). These vague inferences often take on meaning only after litigation has commenced and the plan's attorneys put the unhelpful conclusion (or series of conclusions) into the context of the details of the claim and medical or vocational information which should have been clearly stated to begin with. Transparency and fairness has been supplanted by opacity, mushy explanation, abstruseness, non-clarity and even assertions that stand in direct contradiction to actual file evidence but note of which precise evidence went unmentioned.

Under the statute and under the 2000 regulations, the claim fiduciaries *must* provide "full and fair reviews" of claims for benefits. 29 U.S.C. § 1133; 29 C.F.R. § 2560.503-1(g)(1), (h)(2). The new regulations do not change this requirement. These procedural minimums have LONG required that the claim administrators set forth *the "specific"* reason or reasons —however many there are— for a denial and the basis of the decision. 29 U.S.C. § 1133; 29 C.F.R. § 2560.503-1; *White v. Jacobs Eng'g Group Long Term Disability Benefit Plan*, 896 F.2d 344, 349-350 (9th Cir. 1990); *Saffon v. Wells Fargo & Co. LTD Plan (& MetLife*), 511 F.3d 1206, 1213-1214 (9th Cir. 2008), citing *Booton v. Lockheed Med. Benefit Plan*, 110 F.3d at 1463-64; *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 974 (9th Cir. Cal. 2006) en banc.[1] The new regulations also do not change this requirement, nor do they change ERISA's compulsory provision requiring the denial notice be *written in language likely to be understood by the lay person* in order he or she may know how to appeal it and perfect the claim. 29 U.S.C. § 1133, 29 C.F.R. § 2560.503-1. The economic costs of this requirement were previously studied and addressed in the Federal Register at 65 Fed. Reg.70246 at 70256, and were recently addressed again. The late objectors had the full opportunity to add the costs and concerns not only previously in regard to the 2000 regulations, but had sufficient opportunity to again do so during the Notice and Comment process to the new regulations before that process closed.

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[1]See also, *Wolfe v. J.C. Penney Co., Inc*., 710 F.2d 388 (7th Cir. 1983) (same); *Jorstad v. Connecticut Gen. Life Ins. Co.*, 844 F. Supp. 46 (D. Mass. 1994) (sparse or conclusory reasons insufficient); *Grossmuller v. International Union*, etc., 715 F.2d 853, 857-858 (3d Cir. 1983); *VanderKlok v. Provident Life & Accid. Ins. Co.*, 956 F.2d 610, 616 (6th Cir. 1992); *Weaver v. Phoenix Home Life Mutual Ins. Co.*, 990 F.2d 154; (4th Cir. 1993); *Makar v. Health Care Corp. of Mid-Atlantic (CareFirst*), 872 F.2d 80, 83 (4th Cir. 1989) (dicta); *Short v. Central States* etc., 729 F.2d 567 at 575 (8th Cir.1984) (rejecting "baldfaced conclusions"); *Richardson v. Central States, SE & SW Areas Pension Fund*, 645 F.2d 660, 665 (8th Cir. 1981)

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Under §(g)(3) (2002), (formerly §(f)(3)), the administrator must also provide a description of *the specific information* the administrator would need for the claimant to perfect his or her claim and explain *why* it needs the specific information. Unfortunately, it is a fact that insurers have NOT followed this, instead, at best, usually offering a generic and confusing laundry list of types of general medical information to submit — but which has either already been submitted, or is a list of various types of "diagnostic studies" that exist in the general medical world, but without identifying which are actually directly relevant to the claimant, and explaining why. Other numerous generically-requested items are actually absurd, such as range of motion tests, physical therapy notes, muscle strength or other testing or even unidentified "diagnostic findings" *which have no relevancy to the claimant's particular diagnosis or treatment*. As the Ninth Circuit noted, "fooling someone unfamiliar with the medical terms with irrelevant medical mumbo jumbo" does not satisfy the administrator's statutory duty or Booton. *Salomaa* at 680. When something seemingly 'specific' is mentioned, such as the invitation to the claimant to submit "neuropsychologic testing," it is never accompanied by the names of the specific tests that should be included in the battery and which of the innumerable effort tests are to be administered. The latter technique leaves the field open for the insurer to move the goal posts and reject whatever is submitted because the testing (allegedly) was not specific enough, or one particular test ---now identified--- was not done but (allegedly) 'should have been,' or even that the entire battery is invalid for not including some specific item or stated clinical observation.

Why have the administrators routinely ignored the mandate of this DOL requirement? The reasons are self-evident: *If Claimants were actually told what was needed, and why, and so long as their health coverage would cover it, they would certainly undergo the specific type of test(s)* that either had not previously been done and was needed or that which needed updating. The requisite explanation —with specificity— '*why*' it is needed would help both the claimant and the treating provider ascertain its utility and its sensitivity and understand any specific parts that should be ordered; and the Claimant would submit it/them.

The DOL's emphasis through its detail in the new regulations to ensure actual compliance with this long-stated rule (which is also applied by the courts) will hopefully go a long ways toward eliminating the opacity that has and continues to unreasonably plague adverse decision letters in the insurers' respective efforts to skirt the stated requirements. Because insurers should have been doing this since 2000 (or before), it should not require any increased costs. Fiduciary compliance is essential to upholding the administrative integrity of this statutory scheme. *Fort Halifax Packing Co., Inc. v. Coyne*, 482 U.S. 1, 15 (1987); *Weaver*, 990 F.2d at 157. In contrast, where the required specificity is replaced by opaque, mushy, unhelpful, or conclusory statements accompanied by a generic invitation to submit "medical records" or "whatever" the claimant wants to appeal those opaque reasons —particularly given the requirement for "meaningful" communications articulated by most of the jurisdictions (see Booton)— the only inference to be drawn is that the fiduciary is not being a faithful fiduciary but is playing a purposeful shell game; playing "hide the ball" in its self-interest to avoid having to pay a valid claim (—or significantly delaying payment of the valid claim). It is in the above way that insurers have waited in the weeds until after the denial and after an appeal to only then have an expert in the relevant field review records, answer limited pre-determined questions, the answers to which are already in the claim file, and/or conduct their adequate investigation and ask for certain information ---information would have been readily available upon request if they had just timely requested it before denying the claim. Another very frequently-encountered technique it to shift the investigation to the claimant, then waiting to articulate the details and underlying basis for each point of the denial in the final decision when it is 'too late' for the claimant to respond.

Increased independence and impartiality of the reviewers and/or decisionmakers is paramount and is consistent with what the earliest regulations and underlying purpose of ERISA foresaw. The practice that claims administrators developed

after 2000 of waiting until after an appeal to order an IME, or an FCE or a so-called 'independent' paper review by frequent and repeatedly used physicians and disallow claimants an opportunity to review, comment and address problems they see with such reviews is contrary to the promises underlying ERISA. However, the latter is an adversarial process, in contrast to the primary purpose of ERISA's neutral and objective "internal review process" which is to provide a neutral, nonadversarial dispute resolution process *(Glista v. UNUM Life Ins. Co.*,, 378 F.3d 113 (1st Cir. 2004); *Makar v. Health Care Corp*., 872 F.2d at 83; *Short v. Cent. States*, 729 F.2d at 575; *Amato v. Bernard*, 618 F.2d 559, 568 (9th Cir. 1980)). Litigation cannot meet that objective.

The new regulations' aim to correct this insurer-adversarial approach could well *decrease* the need for second or other voluntary appeals or even later litigation, all to the avoidance of further delay and cost to claimants.

The 2000 regulations ensured employee participants and beneficiaries' effective access to the courts where administrators failed to conform with the standards of the claim regulations —and each of them 29 C.F.R. 2560.503-1, subsections "a" - "o". And as they are each a 'minimum' standard, below which the regulations deem the insufficient process "unreasonable" as a matter of law (29 C.F.R. 2560.503-1(b)) and violate the regulations. 29 C.F.R. § 2520.102-2, the deemed exhaustion provision in the new regulations simply reinforces that which subsection "l" and the related notice and comments had already assured employees in 2000.

The principle of effective access to the court in this remedial statute is also an express notice of the contractual suit limitations period and an accurate assessment of the accrual of the particular claim issue. These each are absolutely necessary to the process. Section 503, 29 USC § 1133, clearly requires conformance with the claims regulations, and as stated above, the 2000 regulations provided for a deemed exhaustion of the Plan's procedures by §2560.503-1(l), 65 Fed. Reg.70246 at 70255 (Nov. 21, 2000)(codified at 29 C.F.R. § 2560.503-1 (a), as do the new regulations. The new regulations' position on the resulting de novo review in a suit adjudicated under subsection "l" is unchanged from 2000. See ERISA, Rules & Regulations for Administration & Enforcement; Claims Procedures, 65 Fed Reg at 70255.

Therefore, Plan administrators and claims administrators including the insurance industry has had abundant opportunity to provide their input during the notice and comment period, both to the prior regulations on areas the current regulations reinforce and reemphasize, and more specific articulation of the Secretary's position in the new regulations. The DOL's decision making process has closed; the long-overdue regulations are well-reasoned and well-stated. The regulations should take effect as stated. They are extraordinarily important to the adequate protection of employee participants and beneficiaries, and the effective date is on the horizon. I vehemently oppose further delay, including the proposed 90-day delay. It should be rejected. Insurers have been in the business of claims investigation and evaluation for well over a century. The new regulations should not implicate any substantial increase in costs, for these reasons and the fact that for the most part, the new mandates are what the 2000 regulations already envisioned, but for the avoidance practices with which the insurance industry treated them. To the extent they claim an increase in cost, those are costs that were envisioned in 2000 related to the same responsibilities that exist in those regulations but have been so artfully skirted for the past 17 years. "Again, the effective date of the regulations should not be delayed. The insurers and Plans had more than enough time to make their case, and the DOL has addressed all of the concerns raised before the process closed. This is just an attempted 'mulligan' by the insurance industry to derail what has been a fully completed and concluded notice and comment process of the Department of Labor —a process that has already closed. It should be seen for what it is.

Respectfully submitted,

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