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VIA E-MAIL (e-ORI@dol.gov) ONLY

U.S. Department of Labor
DOL Regulations Department
200 Constitution Ave. NW
Washington DC 20210

Re: *RIN 1210-AB39*

To Whom It May Concern:

I have represented hundreds of disability claimants in internal appeals and litigation in both ERISA (the vast majority) and non-ERISA claims. I previously commented on the then proposed Claim Procedure Regulations, thereafter adopted, which are now due for implementation January 1, 2018. I read many of the numerous comments submitted by representatives of the insurance industry. I also read the Final Rule, adopted on December 19, 2016.

The current efforts by representatives of the insurance industry to delay implementation of the Final Rule and to alter these regulations are procedurally improper and substantively without merit.

As to procedure: all interested parties had the opportunity to participate in the notice and comment process of the rulemaking procedure. There is simply no legitimate reason to have a "redo." The insurance industry had ample opportunity to comment on the proposed regulations - - and clearly did so. Nothing in the Administrative Procedures Act permits the Department of Labor, after notice and comment and after adopting regulations, to reopen the notice and comment process in order to allow stakeholders to "try again." Of course, the Department may amend or repeal a rule following the same procedures it did to adopt a rule. APA §1.

Second, substantively, the new - - actually old - - concerns of the insurance industry representatives are invalid. They claim that implementing the new regulations will cost the insurance industry more money. They have made similar claims before and the Department of Labor found that those

claims to be without merit. What the insurance industry is really saying, in my opinion, is that the additional transparency of the new regulations will make it much more difficult for claims personnel to deny valid claims and therefore, instead of denying valid claims for improper reasons, the insurance industry will have to grant those claims - - which will cost it more money. One of the purposes of the Final Rule is to encourage transparency and honesty. If transparency and honesty result in more valid claims being paid instead of valid claims being denied, that's a good thing.

After the Final Rule was adopted, the insurance industry claimed that a confidential survey of carriers estimated that the new regulations (the Final Rule) would cause average premium increases of 5 to 8% in 2018. Of course, the industry representatives provided no data to support this, did not provide the referenced survey information, and made no representation that they ever would or could. Let's be realistic: survey data is notoriously susceptible to influence by the nature of the inquiries made. Without actually seeing the data and evaluating the protocols utilized to collect and evaluate that data, these representations are pure speculation.

Furthermore, the variables that might impact disability benefits claims experience and litigation are numerous. The industry's "survey" is meaningless unless all relevant variables have been evaluated. These variables include, but are not limited to:

1. The impact of state bans on discretionary clauses. Obviously, the Department has no standing or authority on this point because state insurance laws are saved from ERISA preemption. Logically, state bans on discretionary clauses have made it more likely that claimants prevail in litigation. On the other hand, the standard of review has no impact on claim decisions or appeal decisions as such; I have deposed claims and appeals personnel from numerous insurance companies and have asked virtually all of them such questions they assert that the standard of review is irrelevant to their decision. (The depositions are typically in non-ERISA cases.)

2. The industry representatives note a referenced increase in premiums resulting in a decrease in covered employees due to Vermont mental health parity statutes. Again, that is an issue of state regulation, saved from preemption and beyond the scope of the Department's authority. Furthermore, other states have similar mental health parity statutes; apparently there is no claim of similar increases in premiums and decreases in participation there. But in any event, the Department has no jurisdiction over state action.

3. The Department is obviously aware that the insurance industry litigation practices substantially increase the cost of litigation - - and thus the overall cost of claims - - by aggressive defense practices intended not to enhance reliability of decision–making in litigation, but to delay the process, impose costs on claimants, and hide evidence developed during the claims process

which demonstrates the invalidity of a claim denial. For example:

a. Insurers routinely dispute that review is *de novo* in litigation under circumstances in which either state bans on discretionary clauses clearly apply or no discretion is reserved in the policy.

b. Insurers and plans routinely omit, delete, or withhold from the Administrative Record documents created, relied upon or otherwise relevant to a claim and force claimants to engage in protracted and expensive discovery contests merely to obtain the complete Administrative Record of a claim.

c. Insurers and plans train/instruct their personnel to routinely violate their fiduciary duties to claimants by misrepresenting or withholding relevant information about, e.g., contractual or statutes of limitation, forcing claimants to engage in expensive litigation contests to enforce their rights not to get benefits, but to pursue claims for benefits.

In my opinion, the Final Rule will likely have no impact on the cost of administering and managing most (likely the vast majority) of disability claims because most disability claims are routine and are routinely granted. In my opinion, what likely drives cost factors (beyond the actual costs of paying claims) are those disability claims which are denied or terminated - - and which likely are ones with more complicated medical issues resulting in longer duration claims and producing virtually all the litigation.

The analysis of these issues is beyond the scope of the 90-day delay proposal. (I intend to provide a further, more comprehensive comment on the merits of rescinding, modifying, etc. the rule by the December 11, 2017 deadline.)

Most of the procedural requirements of the Final Rule are mandated (although not necessary always followed) by case law in some circuits. For example, the requirement to give appropriate weight to a Social Security award and the requirement that medical reviews post-appeal be provided for comment to the claimant are enforced (usually) in the Ninth Circuit. Therefore, whether or not that standard is adopted by regulation, it is nonetheless in effect for at least part of the country.

The Final Rule requires more detailed disclosure requirements by requiring insurers and plans to provide the claim file and internal protocols, allow review and responses to new information, minimize conflicts, and deemed exhaustion standards are routinely enforced by courts - - although admittedly not consistently so. The assertion that these regulations, as such, will increase premium rates and thus decrease participation rates, appears to me to be utterly

disingenuous and not founded on facts. Here is the reality: Every insurance carrier and third party administrator has standard processes and practices for evaluating, adjudicating, and managing disability claims. All of them routinely train their personnel and routinely provide updated on-the-job training. (I have deposed claims and appeal representatives of numerous insurance companies, mostly in bad faith claims, but also in ERISA claims, about precisely these issues.) It will be simple enough - - and not at all costly - - to implement new procedures to effectuate the Final Rule. These procedures only impact the outcomes and thus cost factors to the extent that they increase the likelihood that claims will be paid rather than not paid. Since the procedures encourage transparency, that is wholly appropriate. But it is likely, in my opinion, that these procedures do not increase the number of claims being paid at the claim level, they just make it more likely that the claimant can prevail at the litigation level because the claimant will have access to complete information. That is a good thing. So it is likely that is what may drive cost increases, if any, - - because likely improving prospects for claims to be granted - - are issues beyond the scope of the Final Rule or beyond the scope of the jurisdiction of the Department, such as bans on discretion and parity acts. (I also believe that requiring transparency as to medical reviews and vocational reviews will increase prospects for claimants to prevail in litigation. This is a point I made in my comment of January 19, 2016.)

The Department is obligated to comply with E.O. 13771, but that does not require or permit the Department to delay implementation of the Final Rule. That is, the adopted Final Rule should be effective on schedule and the Department can now and thereafter investigate and evaluate whether modifications are thereafter warranted if the regulations appear to be burdensome. But merely because the insurance industry claims that the regulations are burdensome without providing any documentation or data to support that claim or demonstrating that increased costs are attributable to state action beyond the scope of the Department's jurisdiction or to its own litigation practices is misplaced. The industry suggests that there will be a complex data collection and sanitation process required to provide the data, if the data is to be relied upon. Candidly, I would love to see that data, as well, but I doubt any of us ever will. Second, even if the industry provides data, it will be meaningless because there are simply too many variables to test and analyze. It will prove to be at least very difficult, and likely impossible, to design an analytical protocol to identify and test for the possible variables, and to collect the data, and analyze the data. Even if designing the protocol is possible and the data collection goes forward, it will undoubtedly take years, not months, to collect the data, analyze it, and provide a report. Let's face it: it's not enough, in effect, to hand the Department a figurative snow ball and say, "look, isn't this proof that there is no global warming?" So, what the industry is proposing is delay for delay's sake and for no other reason.

Finally, the Department's rationale for the 90-day delay in implementing the Final Rule appears to be that the delay will allow it to obtain 11 categories of data from the insurance industry and analyze that data to assess impacts of the Final Rule on disability insurance costs.

First, insurers will not provide the requested data, if only because insurers which provide such data, even sanitized through a third party, to You, will be in no position to refuse such data to me (and others) when it is requested in litigation. Let's face it: such data would certainly potentially be discoverable and relevant in insurance bad faith litigation in jurisdictions (such as California) which recognize that tort. Second, is the Department asking for such data only as to ERISA claims? Do you really think insurers will provide such differentiated data? Or even know? In my experience, insurers often mischaracterize non-ERISA claims as subject to ERISA. In my experience, individual policies are sometimes subject to ERISA. I am a sole practitioner, my current active (in litigation or in the process of an internal appeal) cases include one disability claim involving an individual policy subject to ERISA because of the manner in which the policy was marketed and one claim arising out of a group policy not subject to ERISA, but in which the insurer regularly asserted that it was subject to ERISA in letters to my client. My point: It's not likely the Department will get any meaningful data and if it does get any data, it will take much more than 90 days to analyze and evaluate it.

In conclusion, the request to delay implementation of the Final Rule, in light of "new information" from the insurance industry should be denied and the Final Rule should be implemented on schedule, as adopted. Certainly, the Department can properly thereafter evaluate the effectiveness and costs of the Final Rule. I will address that issue more comprehensively later. For now, it is sufficient to note that such a multi-variable analysis will require both comprehensive and candid data from the insurance industry, including, quite obviously, information and data that insurers routinely assert to be proprietary and trade secrets. There is a very strong argument that insurers which voluntarily provide such information waive trade secrets, etc. protections, so they won't. Realistically, while the Department can "work with stakeholders to ensure that any trade secrets and proprietary business information are protected from public disclosure, " the mere act of providing such information voluntarily puts such information into the public sphere and outside trade secret protections, something insurers clearly understand. I was primarily an insurance defense lawyer for 20 years; I suspect that my friends in the defense bar will advise their clients not to disclose this information. So, the proposed delay will serve no real purpose - - other than delay for delay's sake.

Very Truly Yours,

ROBERT J. ROSATI

RJR/lkc