Office of Regulations and Interpretations,
Employee Benefits Security Administration
Room M-5655
U.S. Dept. of Labor
200 Constitution Avenue NW
Washington D.C. 20210

Re: Re-Examination of Claims Procedure Regulations for Plans Providing Disability Benefits
RIN No.: 1210-AB39
Regulation: 29 C.F.R. §2560.503

Dear Deputy Assistant Secretary Hauser:

I am writing to discourage the Department from modifying or further delaying the final disability claims regulations (Final Regulation on Claims Procedure for Plans Providing Disability Benefits, 81 Fed. Reg. 92316 (Dec. 19, 2016)) that are now scheduled to go into effect on April 1, 2018.

I am interested in the content of these regulations because, as a partner at McMahan Law Firm, LLC, I primarily litigate ERISA disability, health and life insurance claims on behalf of individuals who have been wrongfully denied their benefits. I also have a Social Security disability practice and am certified as a specialist in Social Security Disability Law by the National Board of Social Security Disability Advocacy. I am a 1996 graduate of Washington University School of Law and am licensed in Georgia, Tennessee and Illinois. I have been a leader in prominent organizations such as the American Association for Justice (AAJ), Tennessee Association of Justice (TAJ) and the Tennessee Bar Association (TBA). I am past-Chair of AAJ's Disability law Section, a former member of TAJ's Board of Governors, past-Chair of TBA's Disability Law Section and past-President of the Chattanooga Trial Lawyers Association (CTLA). AAJ, TAJ, TBA and CTLA are all associations of lawyers who advocate on behalf of disabled or injured individuals. Additionally, I have lectured regularly on disability issues to other attorneys in multiple jurisdictions.

I appreciate the opportunity to comment on the Department's re-examination of the costs of the final rules governing disability claims. However, the concerns raised by the industry are not new but simply a re-argument of the merits of the final rules. Because those rules are based on policy choices made by Congress, this Department, and the federal courts interpreting ERISA, another argument about the merits is unnecessary.

Nevertheless, I will address the industry's objections that I feel are most in need of a response.

Insurance Companies are ERISA Fiduciaries

Before I respond in earnest, let me respectfully remind the Department that an insurance company, as the party obligated to pay benefits and the administrator given discretion in construing and applying the provisions of a group health or disability plan and assessing a participant's entitlement to benefits, **is a fiduciary**. *See* 29 U.S.C. § 1002(21)(A)(i) and (iii); *Aetna Health Inc. v. Davila*, 542 U.S. 200, 220, 124 S. Ct. 2488, 2502 (2004); *Mondry v. Am. Fam. Mut. Ins. Co.*, 557 F.3d 781, 803 (7th Cir.), *cert. denied*, 130 S. Ct. 200 (2009). This cannot be stressed too strongly. As a fiduciary, an insurance company is required to carry out its duties with respect to the plan "solely in the interest of the participants and beneficiaries and—(A) for the exclusive purpose of: (i) providing benefits to participants and their beneficiaries;…[and] (B) with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims…" 29 U.S.C. § 1104(a)(1). Under the law of ERISA an insurance company owes the participants in its plan and their beneficiaries a duty of loyalty like that borne by a trustee under common law, § 1104(a)(1)(A), and it has to exercise reasonable care in executing that duty, 1104(a)(1)(B). *Mondry*, 557 F.3d at 807. The final rules should be reviewed in this context.

Costs Will Not Increase

The industry claims the final rules will increase costs that will increase premiums resulting in less access to disability benefits. The industry is wrong. This costs argument was made in various industry comments to the proposed rules before final adoption. The Department concluded that costs would not outweigh the benefits. The current complaint of increasing costs has already been considered and rejected. The Department should rely upon information supplied by its own Bureau of Labor Statistics. https://www.bls.gov/opub/btn/volume-4/disability-insurance-plans.htm. The data shows that access and participation in employer-based disability insurance has *increased*, not decreased, between 1999 and 2014. One should therefore be skeptical of any data supplied by the industry now that suggests employers would abandon disability coverage due to the costs of codifying these principles. The BLS document shows that the cost of disability insurance is extremely modest. Thus, even if costs did increase, the increase would be small and make little, if any, difference. The Department should not change the final rules in response to the industry's evidence-free argument that the costliness of the final rules will impact access to disability benefits in the workplace.

The Benefits Outweigh the Costs

Whatever the costs of the final rules, they could never outweigh the benefits. The Department's articulated purpose is to ensure claims are fairly adjudicated and to prevent unnecessary financial and emotional hardship. Or, in other words, the Department is simply requiring the industry to accept its obligations as a fiduciary. The Department must not abandon these purposes. Moreover, these benefits cannot be outweighed by costs where the ERISA process is already so slanted in favor of the plan administrators. In ERISA there is no right to a jury trial, punitive damages are prohibited, there is a closed record from the claims process that can rarely be supplemented in litigation, and

discovery is extremely limited. Indeed, under ERISA an insurance company can win a case even if its decision was wrong because a plaintiff has to prove that the insurance company's decision was both wrong and unreasonable. Accordingly, ERISA will never be a level playing field much less one that favors plan participants. *United States v. Aegerion Pharmaceuticals, Inc*., 2017 WL 5586728, at *7 (D.Mass. 11/20, 2017)("The insurance industry found it could largely immunize itself from suit due to the Employee Retirement Income Security Act ("ERISA").) Even with the final rules in place, plan participants will not have achieved the "higher-than-marketplace standards" that the Supreme Court insists are required in processing ERISA claims. *MetLife v. Glenn*, 554 U.S. 105, 115 (2008). Any consideration the Department makes about the benefits of the final rules relative to costs should take this "higher-than-marketplace" expectation into account and acknowledge that ERISA exists to protect plan participants.

Requiring the Plan to Discuss the Basis for Disagreement with Social Security Decisions or Other Contrary Opinions is Not Costly.

This rule merely requires disability plans to observe a fundamental due process principle imbedded in ERISA—that a claimant is entitled to a well-articulated explanation for the adverse benefits decision so that the participant may fairly dispute it. The 2000 regulations require no less. Many individuals who have long-term disability ("LTD") ERISA claims also have claims for Social Security Disability benefits. Moreover, many insurance companies require LTD claimants to file for Social Security disability. This is done because most plans offset the LTD benefit by the Social Security disability benefit and this reduction is considered by the insurers to be one of the most important cost containment features of their LTD contracts (and is usually termed "recovery of an overpayment"). In fact, insurance companies that issue LTD plans will commonly direct an insured to contact a specific representative to assist him or her in obtaining Social Security disability benefits. However, when the Social Security Administration finds favorably for a claimant the insurance company will commonly reject the analysis of the Administration. It is as bad as it sounds. In other words, it is not unusual for an insurer to require that an insured file for Social Security disability benefits, suggest a specific representative to hire, recover the "overpayment" from its insured once the Social Security Administration finds in the claimant's favor, and then deny the LTD claim though it is based on nearly identical arguments that the suggested representative made in front of the Administration. Insurance companies can get away with doing this because under the law an ERISA decision-maker is not automatically bound by the findings of the Social Security Administration that a person is disabled. *See, e.g., Whitaker v. Hartford Life and Acc. Ins. Co.*, 404 F.3d 947, 949 (6th Cir. 2005).

Fortunately, however, at least for the moment, an ERISA decision-maker is not free to ignore the decision of the Social Security Administration, and the fact that a person has been found disabled by the Administration is a factor a court should consider, in the context of the record as a whole. *Calvert v. Firstar Finance, Inc.*, 409 F.3d 286, 295 (6th Cir. 2005). Significantly, in *DeLisle v. Sun Life Assur.Co of Canada,* 2009 FED App. 0082P (6th Cir. March 4, 2009), the court explained that while a Social Security award does not automatically mean the claimant is entitled to benefits under a private disability

plan, the court cited *Bennett v. Kemper Nat'l Servs.*, 514 F.3d 547, 554 (6th Cir. 2008) for the proposition that "[i]f the plan administrator (1) encourages the applicant to apply for Social Security disability payments; (2) financially benefits from the applicant's receipt of Social Security; and then (3) fails to explain why it is taking a position different from the Social Security Administration on the question of disability, the reviewing court should weigh this in favor of a finding that the decision was arbitrary and capricious." *DeLisle*, 2009 FED App. 0082P at 5-6. This is not problematic – it is the essence of fairness. In any case, as the Department has already noted, it is doubtful that there are costs associated with the requirement of discussing the reasons for disagreeing with a favorable Social Security decision. A rule clarifying that an explanation of the basis for disagreeing with a Social Security decision is a requirement will increase uniformity and predictability in the process, which is generally associated with costs savings and not cost increases.

The Deemed Exhausted Rule is Not Costly

The industry's concern about this rule seems to be that plaintiffs and their attorneys will race into court, increasing the volume of ERISA litigation and hence the overall costs of administering disability claims. This is preposterous. Under the final rule, a plaintiff will typically get a remand with instructions for the plan to do its job. Because plaintiff's attorneys normally work on a contingent fee basis they will not litigate unless it is absolutely necessary. Remember, a plaintiff's attorney must prove that the insurance company's decision was both wrong and unreasonable – not a simple task in even the most compelling circumstances. In any case, as with most of the other final rules, this rule simply codifies existing judge-made law. Claimants are already able to get into court when the claims process has failed them in a meaningful way. *See e.g. Brown v. J.B. Hunt Transp. Servs*., 586 F.3d 1079, 1085-86 (8th Cir. 2009) (failure to respond to request for documents excused claims from exhaustion requirement because there was no full and fair review). It is not likely that additional costs will result from this regulation. *Hall v. National Gypsum Co*., 105 F.3d 225, 231-32 (5th Cir. 1997); *LaAsmar v. Phelps Dodge Corp. Life*, 605 F.3d 789 (10th Cir. 2010); *Nichols v. Prudential Ins. Co. of Am*., 406 F.3d 98 (2d Cir. 2005); *Jebian v. Hewlett-Packard Co. Employee. Benefits Org. Income Prot. Plan*, 349 F.3d 1098 (9th Cir. 2003); *Dunnigan v. Metropolitan Life Ins. Co*., 277 F.3d 223, 231 n.5 (2d Cir. 2002). See also, *Barboza v. Cal. Ass'n of Prof'l Firefighters*, 651 F.3d 1073, 1076 (9thCir. 2011) (When a plan fails to establish or follow reasonable claims procedures consistent with the requirements of ERISA, a claimant need not exhaust because her claims will be deemed exhausted.); *Linder v. BYK Chemie USA Inc.*, 313 F.Supp.2d 88, 94 (D. Conn. 2004) (regulation is unequivocal that any failure to adhere to a proper claims procedure is sufficient to deem administrative remedies exhausted).

Providing the Right to Review and Respond to New Evidence or Rationale From the Plan During the Appeal Review is Not Costly.

This rule is fundamental to full and fair review. The Department has acknowledged the importance of this rule and it is already the standard in many jurisdictions. The industry

complains that providing the claimant with new evidence or rationales before making a final decision is costly. How, exactly? Whether they provide this information to the claimant during the ERISA appeal process, they will have to provide it eventually in one form or another because new reasons or evidence must be included in the claim file and likely again in 26(a)(1) disclosures. If the issue is the cost of mailing, such a concern should not be permitted to interfere with such basic a due process right.

The rule is important. It permits a claimant to respond to a disability claims administrator's assertions in a way that will make the response a part of the record if the claimant has to go to court to vindicate his/her rights. Most ERISA cases are decided on a closed record. Without this rule, the claims administrator's new evidence or rationale will be included in the record that the court reviews, but the claimant's rebuttal will not. Accordingly, the industry is really complaining about its loss of the ability to strategically withhold information that would help the claimant obtain a reversal or win his/her case in court – something it cannot do as a fiduciary. "The duty to disclose material information is the core of a fiduciary's responsibility, animating the common law of trusts long before the enactment of ERISA." *Eddy v. Colonial Life Ins. Co. of Am.*, 919 F.2d 747, 750 (D.C. Cir. 1990). "The administrator of an employee welfare benefit plan…has no discretion…to flout the…fiduciary obligations imposed by ERISA, or to deny benefits in contravention of the plan's plain terms." *Blau v. Del Monte Corp*., 748 F.2d 1348, 1353 (9th Cir.1984). That is what the industry is trying to do here and the Department should not let it.

<u>Other Provisions</u>

<u>The Impartiality Rule</u>

Few industry commenters complained about the proposed rule requiring consulting experts be impartial. Comment #76 (UNUM), Comment #92 (NFL), Comment #129 (AHIP). This muted objections is understandable as it is hard to argue that disability claims administrators should be free to hire biased experts. The majority of those who object to this rule admitted that the proposed rule reflects the existing law. Comment #76, (UNUM), Comment #92 (NFL). The industry complaints are really based on the fear of increased litigation, particularly in the form of discovery. First, federal judges are well versed at limiting discovery in ERISA cases in proportion to the needs of the case. See e.g. *Paquin v. Prudential Ins. Co. of Am*. 2017 WL 3189550 (D. Colo. 7/10/2017); *Heartsill v. Ascension Alliance*, 2017 WL 2955008 (E.D. Mo. 7/11/2017; *Ashmore v. NFL Player Disability and Neurocognitive Benefit Plan*, 2017 WL 4342197 (S.D. Fla. 9/27/2017); *Baty v. Metropolitan Life Ins. Co.,* 2017 WL 4516825 (D. Kan. 10/10/2017); *Harding v. Hartford Life and Accident Ins. Co.,* 2017 WL 1316264 (N.D. Ill. 4/10/2017); *Hancock v. Aetna Life Ins. Co*., 321 F.R.D. 383 (W.D. Wash. 2017); *Kroll v. Kaiser Foundation Health Plan Long Term Disability Plan*, 2009 WL 3415678 (N.D. Cal. 10/22/2009). The courts typically state that ERISA discovery must be limited such that it is "reasonably calculated to lead to the discovery of admissible evidence" under Rule 26(b) of the Federal Rules of Civil Procedure, and "facilitate[s] the prompt and inexpensive resolution of disputes." See, e.g., *Mulligan*, 271 F.R.D. 584, 588 (E.D. Tenn.

2011). Indeed, if the impartiality rule is already the law, how would more discovery result from codifying it? The answer: it will not.

The Rule Requiring Disclosure of any Internal Limitations Period

Few industry commenters focused on the final rule requiring claims administrators to provide the claimant with the date when any internal time limit for filing suit will expire. I am assuming, therefore, that these objectors are not claiming that this rule has a cost impact. The claims administrators are in a position to satisfy this rule, since the expiration date of an internal limitations period is essentially a plan term that should be accessible to the plan administrator and not be hidden from unsuspecting plan participants. As with most of the final rules, information respecting the period of limitations is required to be disclosed in several jurisdictions, so it is unlikely to incur additional costs to create uniformity. *Santana-Diaz v. Metro. Life Ins. Co.*, 816 F.3d 172, 179 (1st Cir. 2016); *Moyer v. Metro. Life Ins. Co*., 762 F. 3 503, 505 (6th Cir. 2014); *Mirza v. Ins. Adm'r of America, Inc*., 800 F. 3d 129, 134 (3d Cir. 2015).

The Rule Requiring Disclosure of Internal Guidelines

Few commenters objected to the proposed rule requiring claims administrator to disclose internal guidelines or certify that none exist. Comment #50 (DRI), Comments #76 (UNUM). These commenters complained that internal guidelines tend to be procedural rather than substantive, implying that the guidelines are irrelevant. As this lengthy rulemaking process has shown, procedure affects substantive outcomes. So even if internal guidelines are procedural, that is no reason to withhold those guidelines from claimants. The disclosure of claims manuals and internal guidelines, which often contain additional plan terms that are hidden from the ERISA participants, will ultimately cut down on litigation, since discovery of these documents is often disputed. *See Glista v. Unum Life Ins. Co. Of Am*., 378 F.3d 113, 123-125 (1st Cir. 2004); *Mullins v. AT&T Corp*., 290 Fed. Appx. 642, 646 (4th Cir. 2008).

Thank you for considering my comments,

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