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**Sent:** Wednesday, December 06, 2017 5:10 PM
**To:** EBSA, E-ORI - EBSA
**Subject:** 1210-AB39

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 write in **opposition** to 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.

My firm, Riemer & Associates, LLC, based in New York City, has been representing long term disability claimants under ERISA since 1994. Our firm has three attorneys and five paralegals and represent hundreds of claimants each year. We represent claimants at every stage of the claim process from helping with claim applications through litigation in Federal Court. I have written a book titled "An Attorney's Guide to ERISA Disability Claims," published by James Publishing in 2014.

The concerns raised by the insurance industry are not new. Indeed, these objections appear to be simply a re-argument of the merits of the final rules. Those rules are based on policy choices made by Congress, this Department, and the federal courts. For the following reasons, the final regulation should be made effective as is.

## I. The Regulation Will Not Increase Costs

The industry claims if the final rules go into effect there will be an increase in costs that will increase premiums resulting in less access to disability benefits. This is untrue.

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 cry of increasing costs is an argument that has already been considered and rejected.

Nonetheless, the Department has asked for data addressing whether costs increased in response to the last set of rules applying to ERISA disability plans that became effective in 2002. In fact,

the Department can 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 access and participation in employer-based disability insurance has *increased*, not decreased, between 1999 and 2014. This increase occurred despite that employment in the service industry has increased, an industry in which employees are the least likely to have access to employer-based disability coverage. This increase also occurred despite the 2000 disability claims regulations and a series of court decisions addressing conflicted decision-making, deemed exhaustion, the need to discuss and explain adverse benefits decisions, and the participants right to respond to new evidence. I would therefore be suspicious of any data supplied by the industry now that suggests employers would abandon disability coverage due to the costs of codifying these principles. This BLS document also demonstrates that the cost of disability insurance is extremely modest. Thus, even if costs did increase, the increase would be so small that it is unlikely to make any difference.

The Department also has asked for data about whether disability premiums increased in response to the adoption of statutory bans on discretionary language clauses in disability policies by some states. Notably, during the time period of the BLS study, many states enacted discretionary clause bans. This includes but is not limited to Arkansas Admin. Code 054.00.101-4 (2013); Cal. Ins. Code §10110.6 (2012); Colo. Rev. Stat. §16-3-1116 (2008); 50 Ill. Admin. Codes 2001.3 (2005); Md. Code ann. Ins. §12-211; Mich. Admin. Codes. R. 500.2201-2202 (2007); R.I. Gen. Law §§ 27-18-79; Tex. Admin. Code §3.1202-1203; Tex. Ins. Code §1701.062, §1701.002 (2011); WAC §284-96-012 (2009). Notwithstanding these statutory developments, access and participation in disability plans increased according to the BLS data.

Also, during the period covered by the BLS document, two major insurers with significant market share, UNUM and CIGNA, were examined by the states for poor claims handling and became subject to fines and Regulatory Settlement Agreements that raised the bar for their claims administration.
http://www.maine.gov/pfr/insurance/publications_reports/exam_rpts/2004/unum_multistate/unum_multistate.html;
http://www.maine.gov/pfr/insurance/publications_reports/exam_rpts/2009/pdf/cigna_mcreport_2009.pdf.
https://www.insurance.ca.gov/0400-news/0100-press releases/2013/release044-13.cfm. Nonetheless, during this period access and participation increased.

Given this history, I dispute any claim that costs will increase in response to the modest changes in the final rules. Accordingly, I urge the Department not to change the final rules in response to the industry's strained assertion that the costliness of the final rules will impact access to disability benefits in the workplace.

## II. Costs Do Not Outweigh the Benefits

Even if, *arguendo*, the new regulation would result in a modest increase in costs, the Department is not required to avoid all regulations that affect the market in some way. *Mkt. Synergy Grp. v. United States Dep't of Labor*, 2016 U.S. Dist. LEXIS 163663, 2016 WL 6948061 (D. Kan. 11/28/2016). As well, it is not clear that, whatever the costs of the final rules, they would outweigh the benefits. The Department has already articulated its purposes – to make sure claims are fairly adjudicated and to prevent unnecessary financial and emotional hardship. The Department should ignore the industry's invitation to 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.

ERISA disability claimants who are denied their benefits face a process that is far below the standard for regular civil disputes. These procedural hurdles include: (1) there are no jury trials; (2) there is a closed record from the claims process that can rarely be supplemented in litigation; (3) courts often apply an unfavorable standard of review, and (4) there are no remedies to discourage unfair and self-serving behavior on the part of plans. This 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.

The Department has already acknowledged that the disability claims industry has been needlessly adversarial toward ERISA disability plan participants and has received many comments to that effect. The industry's argument that the final rules are bad for participants – despite all evidence to the contrary - cannot be taken seriously. The industry is not a credible advocate for participants.

Furthermore, from the perspective of plan participants, an inexpensive but illusory disability plan is worse than no plan at all. It is important to note that when a disability claimant is unfairly denied benefits that he/she thought was promised through an employer's plan, it is too late to go out and purchase private individual insurance to cover the risk of becoming destitute. Disabled claimants are often shocked when they are told about ERISA's procedural hurdles. So, to the extent that increased protections bring disability claims administration in line with the reasonable expectations of the employee-participants, the costs are outweighed by the benefits.

If there are costs associated with the final regulations, these costs could and should be tolerated in the name of supplying a modicum of protection for plan participants.

## III. Distinguishing SSA Determinations Does Not Increase Costs

This rule merely requires disability plans to observe a fundamental due process principle that is imbedded in ERISA—namely the principle 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.

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. ERISA disability benefits have always been deeply intertwined with the Social Security system and mostly are simply supplemental to Social Security benefits. Most disability plans require claimants to apply for the SSA benefit, and the plans usually provide representation for claimants before the SSA. This is done so that the plan may take advantage of the plan term that the SSDI benefit will offset the LTD benefit. Indeed, in many cases the ERISA disability benefit is *de minimis* or non-existent once this offset is taken. In order to decide which claimants qualify for this representation, plan claims handlers need to know the standard that the SSA uses. Comment #114, p.8 (ACLI). Disability claims administrators' operational manuals devote many pages to deciding whether the claimant is disabled enough to be referred to counsel for representation before the Social Security Administration, and how to offset or recover the benefits once they are successful, and how to express all of this to the claimant.

To the extent that the industry argues that increasing the cost of disability insurance will burden the government, and more specifically the SSA, the Bureau of Labor Statistics publication speaks to this:

> It is important to note that expanding access to employer-provided disability insurance would not necessarily relieve the burden on SSDI. The ability to access disability insurance does not affect a worker's eligibility for SSDI. People can receive SSDI benefits and long-term disability payments, but the private disability insurance payment is usually reduced by the amount of the SSDI payment.

https://www.bls.gov/opub/btn/volume-4/disability-insurance-plans.htm.

Additionally, the disability plans and insurers are required in many jurisdictions to discuss why they are denying a disability claim when the Social Security Administration awarded benefits under an obviously more strenuous standard. *Montour v. Hartford Life & Acc.Ins Co.*, 588 F.3d 623, 635-637 (9th Cir. 2009); *Salomaa v. Honda Long Term Disability Plan*, 642 F.3d 666, 679 (9th Cir. 2011); *Bennett v. Kemper Nat. Services* Inc., 514 F.3d 547, 553-554 (6th Cir. 2008); *Brown v. Hartford Life Ins. C*o., 301 F. App'x 777, 776 ($10^{th}$ Cir. 2008). As a matter of Supreme Court precedent, it is arbitrary and capricious for the claims administrator to advocate for Social Security benefits, reap the benefit of the Social Security award by means of an offset, and then ignore the SSA's determination. *Metropolitan Life v. Glenn*, 554 U.S. 105 (2008). As the industry comments often acknowledged, requiring an explanation of the reasons for disagreeing with the Social Security decision and other contrary evidence tracks the existing standard. Logically, it should not increase costs to simply codify this standard.

Moreover, it would appear to increase insurer costs if they need to treat claimants in certain circuits (to satisfy existing case law) different than claimants in other circuits. 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.

## IV. "Deemed Exhausted" Does Not Increase Costs

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 incorrect. Plaintiff's attorneys are ever mindful of building a record on which the court will make its decision and therefore would rather engage in the appeal process and exhaust internal remedies. This serves the dual purpose of possibly resolving the dispute and creating a record for the court to review in case the dispute cannot be resolved internally. Under the final rule, the plaintiff will mostly obtain a remand with instructions for the plan to do its job. Because plaintiff's attorneys usually work on a contingent fee basis, it does not make sense to undertake litigation that is not absolutely necessary and that will not result in resolving the case on the merits.

Further, a court will only award attorney fees for litigation where the plaintiff has achieved some degree of success on the merits. *Hardt v. Reliance Standard Life Ins. Co.*, 560 U.S. 242, 255 (2010). In other words, the industry comments are seriously out of step with litigation in the real world and how the incentives are aligned to discourage litigation. While this rule may appear to create additional trips to court, it will not do so except in the most extreme cases. I take it that addressing these extreme cases is the purpose of the final deemed denied rule.

Additionally, as with most of the other final rules, this rule is simply a codification of 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).

## V. Requiring the Opportunity to Respond to Evidence Does Not Increase Costs

Permitting a claimant the opportunity to respond to evidence is fundamental to full and fair review. The Department has already acknowledged the importance of this rule and that it is already the standard in some jurisdictions. The industry complains that providing the claimant with new evidence or rationales before making a final decision is costly. The industry's claim to cost impact is suspect for several reasons.

First, several disability plans or insurers already provide for the right to review and respond. They do so on a voluntary basis, as their comments to the proposed rules showed. Second, courts require plans or insurers to do this in many cases. Lastly, 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. New reasons or evidence will need to be included in the claim file and likely again in 26(a)(1) disclosures. Thus, the industry's portrayal of the chaos that might ensue if they were required to supply these documents is not credible. If the issue is the cost of mailing, such a concern should not be permitted to interfere with such basic a due process right.

It is important to note what this rule does. 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. This is because 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. Perhaps what the industry is really chafing about is the loss of its ability to strategically withhold information that would help the claimant achieve reversal or win his/her case in court.

There is no question in my mind, after years of experience representing ERISA claimants, that the ability to sandbag the claimant with a new medical opinion that he/she cannot refute, or a new plan provision to rely upon that he/she cannot counter, is a prized device in the disability claims industry. The final rule needs to be kept in place to prevent this behavior from stamping out otherwise meritorious disability claims.

If the industry's concern is that the claims handlers need to do more in the same amount of time, this could be addressed by modifying the rule instead of eliminating the rule altogether. Commenters from both sides have suggested as much.

I also dispute the industry's comments to the effect that a second appeal, which is offered with some plans, serves the same purpose as the right to respond to new evidence or rationales before a final decision. This is clearly not true, as a second appeal permits the claims administrators the same sandbagging opportunity as the first appeal. Second appeals are not necessarily a boon to plan participants. Additionally, second appeals are not universal and are not required. The second appeals that the industry touts are a matter of plan design and can be changed at any time by plan sponsors. It may be that second appeals will become obsolete where the claimant has a true right to respond.

Sincerely Yours,

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