**From:** Robert Keehn [mailto:rkeehn@rfk-law.com]
**Sent:** Thursday, December 07, 2017 5:16 PM
**To:** EBSA, E-ORI - EBSA
**Subject:** RIN 1210-AB39

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 of Labor 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 currently will become effective as of April 1, 2018.

I work extensively in the field of ERISA disability and medical claims, representing claimants who typically are in dire need of the assistance provided by the DOL's regulations. I have a broad – and, I believe, balanced – perspective on this, as I used to represent insurers and benefit plans in this same area.

Initially, it's important to recognize that the concerns raised by the industry are not new. Not at all. Rather, these objections simply are the industry's effort to "take another crack" at the merits of the final rules. Those rules don't need yet another slew of negative comments by the industry. To the contrary, the rules are derived from sound policy choices made by Congress, by the Department, and by the federal courts interpreting ERISA. At every turn, the industry has fought against those policy choices. The industry having been rebuffed previously, there's no need to slog through that again.

Nevertheless, I will address the objections that have been raised that I feel are most in need of a response.

1. **<u>Costs Will Not Increase</u>**

The industry asserts that if the final rules go into effect, there will be an increase in costs that will increase premiums and resulting in reduced access to disability benefits. That assertion is exceptionally hard to believe.

This same argument was made by the industry even before final adoption of the proposed rules. The Department disagreed, and concluded that costs would not outweigh the benefits. An agency is not required to "conduct a formal cost-benefit analysis in which each advantage and disadvantage is assigned a monetary value." *Michigan v. Environmental Protection Agency*, 135 S. Ct. 1699, 2711 (2015).

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

fact, the Department is able to 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. This increase 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 participant's right to respond to new evidence. I am therefore very skeptical about any data supplied by the industry now that suggests otherwise. The BLS document also demonstrates that the cost of disability insurance is quite modest. Therefore, even if costs did increase, the increase would be *de minimis* from an overall perspective.

The Department has also 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. 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 provided for and required more exacting claims administration. Nonetheless, during this period access and participation *increased*.

Given this history, it's just not credible to contend that costs will increase in response to the modest changes in the final rules. I urge the Department *not* to change the final rules in response to the industry's arguments.

### 2. The Benefits Outweigh the Costs

The Department is not required to avoid all regulations that affect the market in some way. *Market Synergy Group v. United States Dept. of Labor*, 2016 U.S. Dist. LEXIS 163663, 2016 WL 6948061 (D. Kan. 2016). It is not at all clear that whatever the costs of the final rules, those costs would outweigh the benefits. In fact, the opposite is true. The Department has already explained its purposes – to make sure claims are fairly adjudicated and to prevent unnecessary financial and emotional hardship. The Department should ignore the industry's efforts to undermine these purposes. Logically, moreover, these benefits cannot be outweighed by costs where the ERISA process is already so slanted in favor of insurers and other plan fiduciaries.

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. 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. *Metropolitan Life Ins. Co. 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. Needless to point out, the industry is not a credible advocate for plan participants.

If in fact there are costs associated with the final regulations, these costs can and should be tolerated in the name of providing a basic, reasonable level of protection for plan participants.

### 3. 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 that is imbedded in ERISA – a claimant is entitled to a thorough 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 SSDI 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 SSDI benefit, and the plans often provide representation for claimants before the Social Security Administration. This is done, of course, so that the plan can take advantage of the fact that the SSDI benefit will offset the LTD benefit. Indeed, in many cases the ERISA disability benefit is minimal or non-existent once this offset is taken.

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 has 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. Co.*, 301 Fed. Appx. 772, 776 (10th 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 SSDI award by means of an offset, and then ignore the Social Security Administration's determination. *Metropolitan Life Ins. Co. v. Glenn*, 554 U.S. 105 (2008). As industry comments frequently acknowledge, requiring an explanation of the reasons for disagreeing with the SSDI decision and other contrary evidence tracks the existing standard. Plainly, it will not increase costs to simply codify this standard.

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, *not* cost increases.

### 4. 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 logic is flawed. 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. *Brown v. J.B. Hunt Transp. Services, Inc.*, 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., etc.*, 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).

### 5. 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 basic and 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 highly suspect for several reasons.

First, several disability plans or insurers already provide for the right to review and respond. They do this on a voluntary basis, as their comments to the proposed rules

showed. Second, courts require plans or insurers to do this in many cases. Third, whether or not 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 F.R.Civ.P. 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 a basic, fundamental due process right.

It is important to note what this rule does. It permits a claimant to respond to a disability claims fiduciary'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. As noted earlier, most ERISA cases are decided on a closed record. Without this rule, the claims fiduciary's new evidence or rationale will be included in the record that the court reviews, but the claimant's rebuttal will not. There is no remotely logical or good faith argument against this rule.

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 the case, as a second appeal permits the claims fiduciaries the same sandbagging opportunity as the first appeal. Second appeals are not necessarily a boon to plan participants, anyway, as they simply consume more time following the adverse benefits determination. In any event, 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.

### 6. Other Provisions

A. The Impartiality Rule

Few industry commenters complained about the proposed rule requiring that consulting experts be impartial. Comment #76 (UNUM), Comment #92 (NFL), Comment #129 (AHIP). These muted objections are 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 seem to be based on the fear of increased litigation, particularly in the form of discovery. That fear is misplaced. First, federal judges are well versed at limiting discovery in ERISA cases in proportion to the needs of the case. Second, if the impartiality rule is already the law, it is not clear how *more* discovery would result from codifying it. Third, the credibility of experts who are opining on whether a claimant qualifies for benefits should be subject to *some* degree of scrutiny. If a claimant needs to conduct discovery into whether a physician hired by the administrator is well-known to support denials, the cost of conducting this discovery cannot possibly outweigh the benefits. ERISA claimants are entitled to a process that does not have a predetermined outcome based on which reviewing physician is hired by the plan. This final rule addresses a serious, recurring problem in the ERISA disability claims process and should be retained.

B. 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. This suggests, therefore, that these commentators are not claiming that this rule has a cost impact. The claims administrators obviously 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. And as with most of the final rules, a requirement for disclosing the period of limitations already is the law in several jurisdictions, so it is unlikely to incur additional costs to create uniformity.

C. 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, however, 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 reduce litigation, since discovery of these documents is often disputed.

Thank you for considering my comments.

Sincerely,

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