Ober Pekas
ATTORNEYS AT LAW

ATTORNEYS
Edward M. Ober
Jeremy D. Pekas
Erin Rose Ronstadt
Kevin Koelbel
Clayton W. Richards
Charles Scrivner

OF COUNSEL
Mark Caldwell

OBER & PEKAS, PLLC
3030 North 3rd Street
Suite 1230
Phoenix, Arizona 85012

PHONE
602.277.1745

TOLL-FREE
800.572.6222

FACSIMILE
602.277.0346

OberPekas.com

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Deputy Assistant Hauser
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*

Deputy Assistant Secretary Hauser:

I am writing to oppose modification or further delay in implementing the final disability claims regulations (Final Regulation on Claims Procedure for Plans Providing Disability Benefits, 81 Fed. Reg. 92316 (Dec. 19, 2016)) (the "Final Rules") scheduled to go into effect on April 1, 2018.

I have been in practice for 22 years, but base my comments on my last 17 years of law practice, which have focused on representing disability claimants under ERISA. My current firm's practice includes helping the disabled obtain Social Security disability benefits and long-term disability benefits. I represent ERISA claimants in the administrative appeal process, Arizona District Court, the United States Court of Appeals for the Ninth Circuit, and successfully opposing a petition for certiorari to the United States Supreme Court.

I appreciate the opportunity to comment on the Department's ("DOL's") reexamination of the Final Rules, but the industry's concerns are not new. The objections are the same concerns raised and reviewed related the merits of the Final Rules. Those rules are based on policy developed by Congress, the DOL, and federal courts interpreting the Employee Retirement Income Security Act of 1974 ("ERISA"). Revisiting and reexamining the merits is unnecessary. But, on behalf of the claimants whom ERISA is intended to benefit, I will comment.

Executive Order 13777 directs agencies to evaluate existing regulations to make them less burdensome. The Final Rule does that for people affected by ERISA. While the Final Rule makes certain burdens imposed on Plans explicit, it does not impose any new burdens. The Final Rule only clarifies what information Plans should have been providing claimants all along.

The Final Rules Will Not Cause An Increase In Premiums Or Decrease Access To Disability 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). Nevertheless, during

the original comment period, the DOL balanced the interests of claimants and the industry and concluded that costs would not outweigh the benefits.

The DOL sought data related to costs increases after the 2002 changes to the rules became effective. The Bureau of Labor Statistics supplied information the DOL can rely. 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* between 1999 and 2014, despite an increase in employment in the service industry, which is least likely to provide employer-based disability coverage. The increase occurred despite the changes to the regulations and court decisions imposing requirements on plans, *e.g.,* accounting for structural conflicts of interests, "deemed exhausted" administrative processes, having to discuss and explain adverse benefits decisions including rejection of treating physician opinions and Social Security Administration ("SSA") determination, and requiring that participants be permitted to respond to new evidence presented by plans or insurers during the administrative appeal process. Industry generated data that suggests a result contrary to the DOL's data is pure speculation. The DOL's data also shows that even as states banned discretionary clauses (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)) participation in disability plans increased. During the same timeframe, UNUM and CIGNA, who have a significant market share, entered into Regulatory Settlement Agreements that required more careful claims administration. And, access and participation still increased.

The evidence shows past industry speculation about cost increases was wrong. I urge the DOL not to change the Final Rules in response to the industry's purported concerns about cost and access to benefits.

The Benefits Of The Rules Outweigh Potential Costs.

The DOL is not required to avoid all regulations that affect the market. *Mkt. Synergy Grp. v. United States Dep't of Labor*, 2016 U.S. Dist. LEXIS 163663, 2016 WL 6948061 (D. Kan. 11/28/2016). And, even if the market is affected, the costs of the Final Rules are not likely to outweigh the benefits. The purpose of the Final Rules is, as the DOL has stated, to make sure claims are fairly adjudicated and to prevent unnecessary financial and emotional hardship. The industry is inviting the DOL to abandon that purpose. That invitation is contrary to the express purpose of ERISA.

Under ERISA, claimants appealing denials of disability benefits face a process less favorable than available under state laws. ERISA handicaps claimants in the following ways: (1) no jury trials; (2) a closed "administrative"[1] record

[1] Although the record on appeal is frequently referred to as an "administrative" record, that record is not a true administrative record because it is not developed by a governmental administrative agency with expertise in a particular area. Rather, the record is developed and maintained by a party with a vested financial interest in the

controlled by an adverse party, with virtually no chance of supplementing; (3) an unfavorable standard of review, and (4) no penalties for a plan's unfair claim handling or self-serving practices. The playing field is never level and will remain tilted in favor of the industry even after the Final Rules become effective. *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). The DOL should consider this "higher-than-marketplace" expectation in reaching a decision.

Illusory disability benefits are worse than no benefits because claimants will forego other protections in reliance on employer sponsored plans. In the Ninth Circuit, where I practice, "[P]rotecting the reasonable expectations of insured, appropriately serves the federal policies underlying ERISA." *Saltarelli v. Bob Baker Grp. Med. Trust,* 35 F.3d 382, 386 (9th Cir. 1994) (citing 29 U.S.C. § 1001). In my state, a "policy may not be interpreted so as to defeat the reasonable expectations of the insured." *Darner Motor Sales, Inc. v. Universal Underwriters Ins. Co.*, 682 P.2d 388, 394-95 (Ariz. 1984). But that is not always the case under ERISA because of the procedural hurdles that favor plans and insurers. If the Final Rules align with claimants' reasonable expectations, the rules are correct.

Perhaps the most frequently arising example of plans not meeting claimants' reasonable expectations relates to Social Security Disability Insurance ("SSDI") benefits. Plans, almost universally, require claimants to apply for SSDI benefits as a condition of receiving the full benefit amount. Otherwise, the plan will estimate the SSDI benefit and deduct it from the plan benefit. Claimants expect that if they receive a favorable decision by the Social Security Administration ("SSA"), which results in a huge savings for the plan's insurer, they will continue to receive the plan benefits. This is particularly so because the SSA definition of disabled is almost always more difficult to meet that any plan's definition. Potential clients come to our office bewildered when a plan terminates benefits *after* the claimant obtained SSDI benefits. Claimants cannot understand how the plan could require them to seek SSDI benefits, often paying for a representative to help them obtain those benefits, and then terminate plan benefits asserting the claimant is not disabled. Claimants are perplexed the plans can help prove to the SSA that they are disabled and then turn around and deny the claimant is disabled. It is reasonable for a claimant to expect that if a plan requires the claimant to represent to the SSA that the claimant is disabled, that when the SSA agrees, the plan will too. Claimants should not have to bear the expense of convincing the plan that required them to convince the SSA of disability, that the claimant is disabled. The burden and expense of explaining a plan's rejection of an SSA decision should fall on the plan. If the Final Rules provide the protection for plan participants ERISA is supposed to provide, any associated costs appropriately born by the plan.

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controversy. Giving virtual total control of the evidence that will be available for judicial review to an interested party and, in most cases, limiting the court to review that party's decision for abuse of discretion, are the greatest impediments to achieving Congress's goal of promoting the interests of employees.

Requiring Plans to Explain Reasons For Rejecting SSA Determination Imposes Little Or No Cost.

The DOL has expressed doubt that requiring plans to explain reasons for disagreeing with a favorable SSA decision imposes any costs on a plan. As noted above, most disability plans require claimants to apply for SSA benefits and usually provide representation to claimants to obtain those benefits. Plans provide their own incentives to this because plans will offset the LTD benefits by the amount of the SSDI benefits. Often, an award of SSDI benefits reduces the LTD benefit to the minimum plan benefit. The industry cannot be serious that explaining its cost savings is too expensive. because it is already required in many jurisdictions. *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 F. App'x 777, 776 (10th Cir. 2008). The Supreme Court declared it arbitrary and capricious for the claims administrator to advocate for SSDI benefits, reap the benefit of the SSDI award by means of an offset, and then ignore the SSA's determination. *Metropolitan Life v. Glenn*, 554 U.S. 105 (2008). Requiring an explanation of the reasons for disagreeing with the SSDI decision imposes no new burden and codifying the requirement will not increase costs. Even if this caused an increase in the cost of disability insurance, it would not burden the government, specifically not the SSA. The Bureau of Labor Statistics publication states:

> 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.

The result of uniformity and predictability in any process is usually a cost saving. The Final Rules requirement of an explanation for disagreement with an SSDI decision will increase uniformity and predictability in the process and is not likely to increase costs.

The Deemed Exhausted Rule Will Not Noticeably Increase Costs.

Plans and insurers object to the new deemed exhaustion provision because it "tilts the balance in court cases against plans and insurers." To be clear, it requires plans and insurers to abide by regulatory deadlines, which aligns with the Congressional purpose of ERISA.

The industry seems to be concerned about increased costs associated with ERISA litigation if plaintiffs and their attorneys have earlier access to the court. But, the litigation will turn on the record developed in the administrative process. Racing to the courthouse before fully developing the record for litigation would be shortsighted. Not only would it compromise the record for litigation, but it would

relinquish the opportunity to obtain benefits without litigation. Racing to the courthouse will likely result in a remand to the plan administrator for proper administration of the claim, putting the claimant back at square one. That is more work than I would be willing to do on a contingency for no benefit to the claimant and no return on my effort. I doubt I am the only plaintiff's lawyer, who would do that cost/benefit analysis. While the court may award fees in ERISA cases, whether a court will award fees for a remand depends on the jurisdiction. The overriding rule is 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). A remand is not always viewed as "success on the merits." The deemed denied rule is not likely to entice plaintiffs' lawyers to make fruitless trips to the courthouse. The proof is that the ERISA common law already allows early access to the courts. *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). And, the industry is not complaining of a rush to litigation. This change to the rule will not even cause a ripple in the way claims are handled.

Providing The Right To Review And Respond To New Evidence Or Rationale From The Plan During The Appeal Review Is Not Costly.

Plan and insurers object to the right of claimants to review and respond to new information or rationales raised after the claimants have appealed an adverse benefit decision. But this does not change the landscape. Courts have always rejected post hoc information or rationales raised after a claimant has exhausted administrative remedies. *See Gabriel v. Alaska Elec. Pension Fund*, 773 F.3d 945, 963, 14 (9th Cir. 2014) (quoting *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 974 (9th Cir.2006)); *Edgerton v. CNA Insurance Co.*, 215 F. Supp. 2d 541, 548 (E.D. Pa. 2002)(court will not defer to post hoc rationales for denying benefits generated during litigation). Allowing Plans or insurers to insert new rationales post-appeal completely defeats the purpose of the regulations claim and appeal processes because the only reason for an adverse benefit decision that will be presented to a district court will be one that escaped prior scrutiny. And, if the claim is not subject to *de novo* review, as is usually the case given the widespread practice of incorporating discretionary language into plans and policies, a claimant will *never* have a full and fair opportunity to have a claim reviewed by a disinterested decisionmaker. Thus, the Final Rules are fundamental to full and fair review.

The industry's claim that barring it from presenting new evidence post-appeal will increase costs is doubtful. Many plans and insurers already provide this opportunity on a voluntary basis. That they would do so, if it was costly, is unlikely. Many jurisdictions require this. The only difference is the timing. If the opportunity is not provided during the administrative process, it is permitted in litigation when it is likely to cost the plan *more* because of attorney involvement. The new reason will be addressed no matter what. The claim of increased cost is false.

The industry's real objection is the removal of "sandbagging" from its arsenal. No longer able to insert new evidence into the administrative record just before litigation makes it more likely claims will be decided on a balanced record rather than one the plan stacks in its favor. The Final Rules bring the playing field close to level.

Internal Limitations Periods Should Be Disclosed.

Plan's and insurer's concerns that the Final Rule will increase litigation no doubt stem from clarifying their obligation to inform claimants of the deadline to commence litigation, which was often missed because Plans or insurers included contractual limitation periods shorter than state statutes of limitations, but did not inform claimants of the shorter period. The Supreme Court in *Heimschoff* concluded those shorter periods are enforceable. Any increase in litigation will be due to claimants being fully informed of the limitations period. That is as it should be given the Congressional purpose of ERISA to promote the interests of employees. *See Firestone Tire and Rubber v. Bruch*, 489 U.S. 101, 101 (1989) (noting Congressional purpose of ERISA is to promote the interests of employees).

Disclosure Of Internal Guidelines Is Already Required

The regulations already require disclosure of all "relevant" documents. 29 C.F.R. § 2560.503-1(m)(8). Relevant documents include any document that "demonstrates compliance with the administrative processes and safeguards required pursuant to paragraph (b)(5) of this section in making a benefit determination." *Id.* Section (b)(5) requires procedures "designed to ensure and to verify that benefit claims determinations are made in accordance with governing plan documents and that, where appropriate, the plan provisions have been applied consistently with respect to similarly situated claimants." 29 C.F.R. § 2560.503-1(b)(5). Arguably, the disclosure of claims manuals and internal guidelines, which often contain additional plan terms that are hidden from the ERISA participants, fall within this scope. Making that explicit will ultimately cut down on litigation, because discovery of these documents will no longer be 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).

Although the industry's claim to need additional time to comment on the Final Rule is, in my opinion, unwarranted, I still appreciate the DOL's thoroughness and this opportunity to make comments. I hope that you find them useful.

Sincerely,

Kevin Koelbel