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VIA EMAIL

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 to express my concern that the Department of Labor not allow further delay regarding Final Regulation on Claims Procedure for Plans Providing Disability Benefits, 81 Fed. Reg. 92316 (Dec. 19, 2016)), presently scheduled to go into effect on April 1, 2018.

By way of background, I graduated from Harvard Law School, magna cum laude, in 1993. I handled my first ERISA disability benefit case in 1994. My practice is presently 100% devoted to representing employees seeking disability benefits under ERISA.

I am aware of the reasons being asserted by the insurance industry in favor of delay, and find those arguments are the same the industry previously raised when opposing the final rules. Those re-heated arguments are addressed below.

Purported Increased Costs:

The industry claims the final rules will result in increased premiums for disability insurance. That allegation is untrue. The Department determined that the costs of the regulations would not outweigh their benefits. It did so after considering data developed following the 2002 changes to ERISA's claims management regulations, which shoed that access to, and and participation in, ERISA governed health insurance increased 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 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 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. 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. Nonetheless, during this period access and participation increased.

Given this history, the industry's claim that the final rules will cause costs to increase, and thereby impact access to disability benefits in the workplace, is simply wrong.

The Benefits Outweigh the 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. Disability claimants, by definition, are not well. They are often exhausted by chronic illness, and have trusted that their treating doctor's certification that they are indeed disabled will be sufficient to allow them to receive the disability benefits they have applied for. I have had to decline representation of people plainly disabled by illness because they have already gone through the administrative appeal process mandated by ERISA, but, due to their lack of understanding of that process, failed to provide the information necessary to prevail in court. 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.

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—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).

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 (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 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.

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 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).

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 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 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. Last, 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.

On several occasions I have represented clients whose insurers, after giving one reason for claim denial, advanced a second, new reason when presented with medical evidence refuting the first – and, in circumstances where the relevant plan allowed a second voluntary appeal, the insurer sought yet another medical opinion when its second reason was shown to be incorrect. The rule simply curbs this kind of adversarial behavior.

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, for the reasons described above – the second appeal permits yet more of the same behavior. Further, second appeals often serve only to delay final resolution, dragging out the process longer while the claimant goes for months without the benefits he or she needs. It may be that second appeals will become obsolete where the claimant has a true right to respond.

Other Provisions

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). This muted objections are understandable, since 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. 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). Next, if the impartiality rule is already the law, it is not clear how more discovery would result from codifying it. Additionally, the credibility of experts who are opining on whether a claimant qualifies for benefits should be subject to some sort 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 problem in the ERISA disability claims process and should remain – particularly when ERISA's processes do not allow claimants the rudimentary due process opportunity to cross examine the experts who have contradicted their own physicians.

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 your consideration of these concerns.

Sincerely,

Mel Crawford